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Trends and Problems in Rural Social and Health Work*

By Dwight Sanderson

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TO my mind the thing which is most fundamental for any permanent and substantial growth of rural social and health work is to arouse a sense of need for it on the part of rural people, to make them aware of the amount of poverty and sickness in their own communities, and that for their own interest as well as to assuage human suffering, there should be an intelligent plan for its treatment and prevention.

Modern social and health work is the product of our large cities, where it grew up out of necessity. In the open country the need for child welfare and family case work and for the control and prevention of disease has not been so apparent. The need is there, but the rank and file are unaware of it. Before any program of rural social or health work can secure permanent support, the better elements in the community must be convinced that it is needed and practical. Except for the American Red Cross, there seems to be no one organization which has sponsored such a movement throughout the country, and unfortunately it seems to have left the initiative largely to the local chapters, and in many counties where such work is most needed local vision and leadership is also lacking. However, in the field of public health nursing the Red Cross has blazed the way and since the World War there has been a remarkable growth of rural public health nurses with an increasing support of their work by public funds.

USE OF LOCAL AGENCIES

It would seem that if any general understanding of social and health work is to be secured in rural counties, it must be promoted by those organizations in which the rural people are already associated and whose objectives and interests involve the consid-

*Excerpts from paper read before the Health and Social Welfare Section of the American Country Life Association Conference, October, 1929.

eration of such welfare movements. If the local farm and home bureaus, the subordinate and Pomona granges, the local parent-teacher associations, farmers' clubs, and similar organizations, can be interested to study their own local situations and consider what might be done for their improvement, a substantial basis for progress will be created.

What is needed is a definite and concrete study of local conditions. Is the drinking water of the rural schools wholesome and safe? In our own county an analysis of the drinking water of 15 rural schools, sampled at random, showed that in four cases the water was unfit for use. What of the medical inspection of our schools? Is it efficient, and if so why are more of the defects reported not corrected? What of defects in eyesight and teeth, which are handicapping rural children, the importance of which their parents do not always appreciate? How many cases of diphtheria, typhoid, and malaria, are there in the community, and what is being done to eradicate these preventable diseases? These and similar questions might be investigated by any local organization, with the cooperation of local physicians and health officials, and would reveal the need for a more adequate service of public health nurses and better health supervision. To outline such local studies and to encourage the local organizations in making them and then following them up with a practical program of improvement, is the opportunity of state and local leaders in all of these organizations which have close contact with the mass of rural folks. The greatest need of the specialized social welfare and health organizations of state and nation is to secure the coöperation of these organizations which are composed of rural people and to furnish them with suitable subject matter and methods for educational campaigns.

Recognizing such a process of self-education as pre-requisite to any real progress, what are some of the essential features of a program of rural social and health work and what are the more outstanding problems? Let us consider health work first, for it seems to make a more immediate appeal, to be more concrete, and leads naturally to a need for better social work.

A RURAL HEALTH PROGRAM

The first step in a rural health program seems to be the employment of a public health nurse, much of whose time is usually given to work with the schools and to general health education. Wherever competent, public-spirited nurses have been employed long enough to demonstrate their value, they have won their way into the hearts of the people and have been the most potent means of creating new attitudes toward better health practices. Whether a nurse be employed by a local chapter of the Red Cross, by a township or county, by a school board, by a voluntary nursing association, or whatever organization may finance her support, the important thing is to secure one *for a sufficient length of time* for her to demonstrate the need of such service. With reasonable management the valuue of her work will soon be recognized and in due time should be supported from public funds.

An unsolved problem in many a rural community is how to keep a competent resident physician. Medical education is expensive, the necessary medical equipment has increased and is more expensive and consequently young physicians are not going to rural communities as formerly. Physicians in smaller cities do not seek rural practice and their prices are necessarily too high for calling them except in emergency. The farmer the farthest from the village, who often has a poorer farm and therefore less cash, has to pay the highest fee and therefore cannot afford adequate medical service. There is no question that in many rural communities there is a real need for a resident physician, but the possible income from fees on the usual basis would be inadequate to give a reasonable living to a competent man.

Various experiments in the employment of a physician on salary or by guaranteeing a minimum income, have been made,* but in the United States, they do not seem to have been so permanently successful as to result in a growth of this method. A thorough study of successes and failures of such efforts is much needed, as with other features of the rural health program, and there seems no reason why the State should not subsidize the employment of a physician wherever there is a sufficient local need. If it is good public policy to subsidize the rural teacher so that country youth may have equality of educational opportunity, why is it not as important to give country people an equal opportunity for medical care and health? This does not mean "state medicine" but partial state support for a physician employed by the locality.

COUNTY HOSPITALS

The state of Iowa was a pioneer in legislation for county hospitals and the movement has now spread throughout the country. There is still, however, a real need for hospitals in many rural counties, providing that they can be financially supported and competently manned. An even more important question in connection with hospitalization is some better adjustment of rates through partial or complete support by taxation, so that middle class and poorer people can afford to use them. Some rural municipalities in western Canada have solved this problem by paying the whole cost of the hospital from taxes and thus equalizing the cost to all. That hospitals are being increasingly used for rural maternity cases is shown by recent figures from Cattaraugus County, New York, in which the number of non-resident births in the cities increased from 22 in 1916 to 194 in 1927.

FULL-TIME COUNTY HEALTH OFFICER

After the public health nurse the most important step in a rural health program is a competent, full-time county health officer. Good progress is being made in the organization of county healthy departments for whereas there were only three county health departments in the United States in 1914, in 1929 there were 467, but the map published by the U. S. Public Health Service showing their distribution is black in spots and white in other areas. Do not rural counties need the services of a full-time public health doctor as well as cities? That such an investment pays good returns on the taxes invested has been demonstrated again and again.

MEDICAL INSPECTION OF SCHOOL CHILDREN

A most important part of the rural health program is the medical inspection of school children. Although medical inspection is now compulsory in many states, it is far too often done in a more or less perfunctory manner and with little effort at follow-up, so as to ensure adequate treatment. The public health nurse is invaluable in securing a better follow-up and seems essential to make medical inspection really effective. In general it seems probable that a better examination would be made if one or two men in a county did all of this work rather than leaving it to the local physicians, and it would be desirable to associate this work with the county health department.

HEALTH INSTRUCTION IN RURAL SCHOOLS

Finally the health instruction in our rural schools should be made the means of ensuring a better appreciation and understanding of health in the coming generation. Too long have we taught anatomy and physiology which failed to function in the personal hygiene of the students. The recent work of the Child Health Committee of the Commonwealth Fund† has demonstrated what can be done in the formation of

* See Carroll A. Streeter, "Ten Dollars a Year Pays the Doctor," in *The Farmer's Wife*, Feb., 1929, for an account of municipal support in Saskatchewan.

† See the most interesting bulletin, "Fargo and the Health Habits," by Maud A. Brown. The Commonwealth Fund Division of Publications, 578 Madison Avenue, New York City.

health habits among school children, and the work of health teachers in demonstrations made by local chapters of the Red Cross has shown the practicability of such work. May we not look forward to the time when we shall have special health teachers in every county, for teaching both teachers and children?

The chief objection to all of these proposals is always the fear of a higher tax rate, and anyone who has had any contact with American agriculture during the past few years cannot but appreciate the need of lowering local taxes. The best method of meeting this objection and of inciting local interest is for the State to give a generous subsidy to all well-conceived programs of public health work, and so equalize the cost throughout the state. Within the county much may be done by scrutinizing the costs of county government and insisting upon a reduction of unnecessary costs and larger expenditures for health work. Finally, it can be shown that even an increase of tax rates would be economy if smaller doctor's bills and less sickness and mortality resulted. In many cases we get more value from taxes wisely expended than from our own private expenditures.

As the public health nurse comes first in the health program, so the child welfare worker is the pioneer agent for rural social work. Everyone is interested in children and in every county there are cases of neglected, dependent, and delinquent children who ought to have the care and help of one who understands their needs and knows how to meet them. Inevitably the child welfare agent meets many problems of family adjustment and before long she is engaged in a general program of social work. In due time she will educate her constituency to see the need of a broad program of family welfare work by both public and private agencies.

JUVENILE COURTS

One of the difficulties of a child welfare worker in most rural counties is that of securing satisfactory treatment of juveniles in the ordinary local courts. Thus the next most important step is the changed attitude of the judges toward juvenile delinquents and incompetent parents and is most surprising. In very many cases these judges are actively educating their constituencies in the need of better social work and are more and more depending upon trained social workers for investigation and supervision. As these courts become more firmly established, it is becoming apparent that many of their cases are due to bad domestic relations, and ultimately we hope that their functions may be enlarged so that they may also become courts of domestic relations.

Much of the practice of the divorce lawyer might be obviated and many divorces might be averted if the methods of juvenile court could be used in their adjustment. In one New York county which has a very low divorce rate, it is the boast of the child welfare agent that there have been no divorces in several years among these couples which have come under her jurisdiction.

COUNTY BOARD OF PUBLIC WELFARE

As rural health administration requires a county health department, so rural social work should be unified under a county board of public welfare with a professionally trained executive officer. North Carolina and Missouri have led the way in this new field, and other states are advancing in this direction by steps.

Child welfare, poor relief, the administration of mothers' pensions, and the care of the neglected, defective, and delinquent, should all be centralized in one organization which is competent to deal with the complex problems involved. But before such a program can be successfully inaugurated, the public must be educated to understand that these difficult problems of human relations cannot be adequately handled merely by the furnishing of grocery orders and clothing, or medical attendance in emergency, by

one whose chief qualification is his or her loyalty to the local political machine, but that they need the service of one who has had the best possible professional training. We have come to understand that we cannot entrust the supervision of public health to anyone but a physician. It is equally important that the baffling problems of adjusting human relationships be entrusted only to those who by study and experience have qualified themselves for such a responsibility.

A FEW GENERAL PRINCIPLES

Out of the experience which has come from these social and health movements in various parts of the country, a few general principles are becoming fairly clear.

The first is that there should be *larger units of administration* so that there may be a sufficient volume of business to employ professionally trained executives. The county is now the most logical unit for the efficient organization of both rural health and social work. In some cases, however, where the population is sparse, or resources are limited, even the county is too small a unit. So we see a general movement for coöperation between a group of counties in the maintenance of a modern and efficient almshouse or in the erection and support of a well-equipped and competently manned hospital. We need to give careful study to the volume of business, the economic basis which may coöperate in such inter-county enterprises and so far as possible make these areas coincident. It is essential that we reconsider the units of rural government from a functional viewpoint and be not held in the grip of past tradition.

If the county is the best administrative unit, how shall its health and social work be organized? A most interesting pamphlet on County Management has recently been published by Professor Wylie Kilpatrick of the University of Virginia, which I commend to your consideration in this connection. In this he advocates the system of appointive county boards of health, education and public welfare to be selected from lists approved by corresponding state departments, who will appoint the executive officers of such boards. Experience seems to show that better officials for the determination of public policy in these fields can be secured by appointment than by election, and that those so appointed because of their interest in and knowledge of such work will be better qualified to select a competent professionally-trained executive to carry out the general policies which they establish. Attempts to make such systems of administration mandatory upon the counties by state legislation have not proven entirely successful, and it would seem wiser to pass permissive legislation with a proviso for as much state aid as may be possible for those counties adopting the new system. Although this procedure may be slow, it provides for the thorough discussion of the merits of the new plan and for the creation of a favorable public opinion before its adoption.

PRIVATE OR PUBLIC AGENCIES?

With such a general scheme of welfare work in view, the question arises as to whether there will still be a need for private agencies for rural health and social work, or whether the whole job may be adequately cared for by the public agencies. The answer to this seems to be at hand in the experience of our cities, in which private organizations for health and social work are as necessary as ever, and to which the people are increasingly generous through community chests, even where the public work is most efficiently administered. As the parent-teacher association is desirable to bring about a better understanding between parents and the educational profession and boards of education, so private associations for health and social work will be necessary for creating and maintaining an intelligent and sympathetic public opinion to support the administration of health and social work and to carry on work which for one reason or another cannot, for the time at least,

be satisfactorily handled by public agencies. Such organizations might well exercise a considerable influence on the appointment of well-qualified boards and competent executives. With mutual good-will and understanding, public and private agencies will find that they support each other and that only through carefully considered team-work can they best advance the general welfare.

RURAL COUNTY CONFERENCES

Finally, may I call attention to what seems to be one of the greatest needs in a general advance toward the program above indicated. In many rural counties there are an increasing number of private or semi-public associations and agencies, seeking support from the general public through personal contributions or through the county treasury. Farm Bureaus, Red Cross Chapters, County Y.M.C.A.'s, Child Welfare Committees, Tuberculosis or Health Associations, etc., etc., are all engaged in social and health work. So too the Granges, the Parent-Teacher Associations, and others. Yet how frequently are the leaders of many of these organizations quite unaware of what the other is doing or how they might more effectively combine their influence toward the common goal! A notable advance has been made in Iowa and Wisconsin, under the leadership of the State Conferences of Social Work, in holding county conferences at which representatives of all these private, semi-public, and public agencies can be brought together for considering the needs of rural social and health work and how they may be met. Such conferences held once or twice a year in each county, will be the means of securing a more accurate knowledge of the real needs, a healthy discussion of better methods of meeting these needs, and in coördination of effort by all these agencies, by informing their membership of just what it is all about and enlisting their united support for all movements which will promote the common welfare. The extension services of the state college of agriculture, the state conferences of social work, and the state leaders of the various organizations mentioned will open up a new field for public service by inaugurating such county conferences in which all those concerned with rural social and health work in a county, or a suitable local district, may come together to consider their common problems and plan a program for their joint solution. The American Country Life Association might perform a most useful function by assembling and circulating the experience, methods, and achievements of such county conferences, so that they may be established wherever, and note this limitation, the local situation is ripe for such an advance and local leadership is available.

NEW PUBLIC WELFARE LAW

A new public welfare law will come into effect in New York State on January 1, 1930, which will supersede the old New York Poor Law, which had not been substantially revised for 100 years or more. Under the old law preventive work for cases not actually destitute was considered by most officials as outside the range of their responsibility. The new law establishes a case-work basis for public relief and definitely places on the public welfare official responsibility for preventive work.

By the provisions of the new measure each county is made a county public welfare district.—*The Catholic Charities Review.*

Orthopaedic Nursing in the Minneapolis Visiting Nurse Association

By Elma Harrison

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IT was physiotherapy morning in the Out-Patient Department at the General Hospital. Miss Smith from the Visiting Nurse staff reached the hospital at eight-thirty. With the aid of her two assistants, she distributed bakers, oil, powder, and other supplies to the several rooms which would be used for treatments in the course of the morning.

Shortly before nine o'clock, Miss Lane, the Junior League volunteer, arrived. Several adult patients had been referred that morning. This meant that she had histories to obtain before the children began to appear, when she would be busy removing wraps and braces. Motor Corps volunteers from the Junior League brought the children to the hospital and returned for them when their treatments had been given. Little Jean, age three, but no bigger than a minute, was one of these children. Though she wore a long leg brace, she had very little difficulty in getting about. Her affected limb she called a "bad boy," and often spanked it for behaving so badly. Her entire leg had been paralyzed. Muscle training was started immediately following the acute stage. Power had returned to the muscles controlling the hip and knee, but she was as yet unable to move her ankle or toes.

The hospital patients also began to arrive. Lawrence came in a wheel chair. He had been a patient in the hospital for six months, a victim of poliomyelitis, which had paralyzed almost every muscle in his body. As soon as his condition permitted, he had been sent to the physiotherapy treatment room for muscle training. When physiotherapy was started function had returned to all the muscles of his legs, but they were very weak. He was able to use his hands somewhat, but there was little motion in his arms.

Organization of Orthopaedic Nursing

The department was organized in January, 1925, following an epidemic of poliomyelitis which had occurred in the autumn. The Visiting Nurse Association saw the need but was unable to finance a new project. The Junior League assumed the financial responsibility, and up to the present time is supporting the work entirely. It has been developed from the first as a special service of the Visiting Nurse Association.

The staff now consists of a specialized supervisor, and two full time nurses. Besides these, a fourth nurse changing every three months is selected from the general staff. During their three months' stay in this service, these selected staff nurses become familiar with orthopaedic terms and conditions; they learn the fundamentals of massage, how to prevent deformities, and when orthopaedic treatment is most beneficial. They form a relief group which can be called upon as need arises.

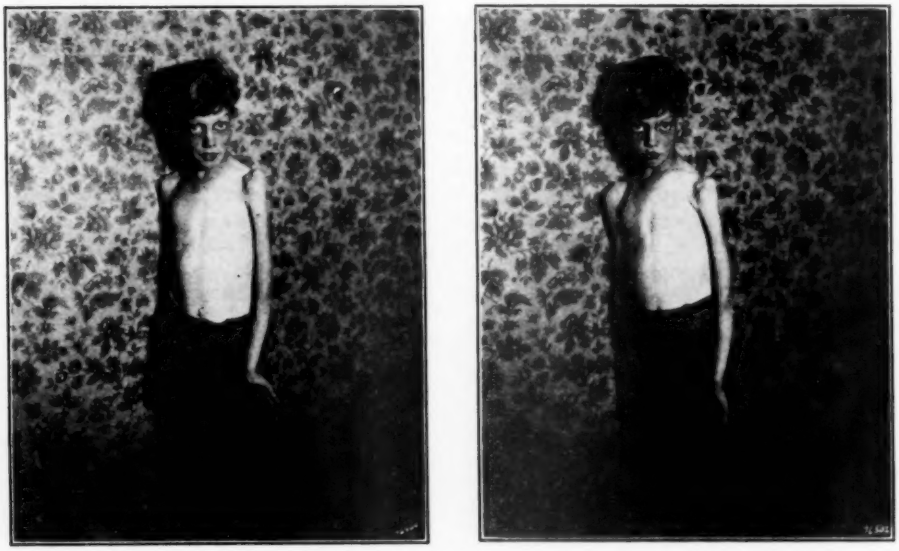
The specialized orthopaedic nurses have always been selected from the regular staff on the basis of their fitness for and interest in this type of work. After a year in the orthopaedic department, each of them is granted a scholarship, which enables her to take the summer course in physiotherapy at Harvard Medical School.

Growth of the Work

During the year 1928 three nurses gave 5,800 treatments to 425 patients. This number of treatments was possible because of an arrangement with the General Hospital one year after the

organization of the department. It was impossible for the physiotherapist employed during the first year to see all her patients in their homes, so rooms were obtained in the out-patient department of the hospital, where treatments are given three mornings a week. The equipment is furnished by the Junior League. The electricity and such supplies as linen, powder, oil, etc., are provided by the hospital. At first only the children who were previously carried were treated there. Gradually both adults and children were referred over to the department as soon as the acute stage is over, which makes less opportunity for them to seek faith cures and "quacks." Two cars are furnished by the League to help the nurses reach their home patients.

Although fracture and injury cases form the largest percentage of the work, it is the after care of poliomyelitis in which the nurse becomes most vitally interested. The preschool child, so afflicted, is carried until he has reached kindergarten age. Children of school age too receive



As he was—John—As he is

from the out-patient department, and physicians began sending hospital cases until at present there are from 30 to 35 patients treated each morning.

About one year ago, a contract was made whereby the city pays $1.10 or the actual cost per treatment for all injured city employees referred to this department.

The district work continues to grow in proportion to the work in the hospital. Patients are sent home with orders for home follow-up by the nurses. Private cases are referred by doctors who learn to know of the work through the hospital. Patients who have had infantile paralysis are turned muscle training until their physicians feel they are able to attend the City School for Crippled Children. And finally, the child who completes his elementary education and still needs muscle reëducation, is again referred to the nurse who continues the treatment which was given in the school. This close coöperation with the hospital and school is felt to be very valuable, and makes for the continuation rather than a duplication of effort.

FILLING THE NEED

There are but few crippled children in Minneapolis who do not receive fairly prompt medical attention. A

recent survey made by the Hennepin County Association for Crippled Children has proved this. There is a school for children who are crippled, with excellent medical and physiotherapy supervision. Clinics and hospital beds are increasingly available. In spite of all these, children may suffer for lack of expert orthopaedic nursing in their homes, between the periods when they are in special schools or hospitals.

John, who is seen in the accompanying picture, is an example of this. He had been a patient of the State School for Crippled Children, where he received expert treatment. When, however, he returned to his farm home, all treatment was discontinued. John, unguided, attempted to use his hand and arm as best he could with the result that certain muscles were over-developed and others which were very weak became practically useless. A few weeks ago, John's parents moved to Minneapolis, where John was referred to the Visiting Nurse Association for care, and he is already beginning to use his hand correctly.

The objective, then, of the Visiting Nurse Association, and of the Junior League, is to coöperate with all existing agencies for the care of the crippled and as a special contribution to make skilled orthopaedic nursing and physiotherapy available at home for every crippled person in Minneapolis who needs it.

CLEVELAND'S HANDICAPPED CHILDREN

Cleveland has a separate school for deaf and partially deaf children, also a separate school for badly crippled children. These schools have the regular nursing service. The children are examined by the doctor in the presence of the nurse, who later follows up all physical defects. The nurse maintains dispensary hours for first aid, infections and dressings. In the crippled school there are many dressings, old chronic bone infections, and in the deaf school there are many discharging ears to be cleaned daily. We have no special classes for cardiacs.

OPEN AIR CLASSES

Candidates for open air classes include non-communicable tuberculosis, cases of tuberculosis exposure, grave cases of malnutrition, atrophic rhinitis, and other cases which, in the judgment of the school physician, should be admitted. A typical child whose physical condition is below par is referred to a special class instead of an open air class.

The candidates are selected by the school doctor in the first two weeks of each term. Each child is given a careful examination on entering the Open Air Class, and again checked at the end of the term. The nurse keeps a waiting list of all special cases requiring a monthly examination. The school doctor visits the Open Air Class at least once a month.

Each nurse has one nutrition class. The purpose is to get together in groups a number of children who need to be taught health habits. A class contains not more than 15 children. A child 10 or 12 pounds below average for height and weight (Baldwin scale), plus general appearance, plus diagnosis of physical after physical examination, is admitted to the class.

The class meets every two weeks during the term for one-half hour. The children assemble, are weighed and weight recorded on wall charts. Height is taken at three-month intervals. Each child is questioned as to diet and daily life. Health talks are given.

Cora M. Templeton, Director Division of Health Nursing Service

Service Norms and Their Variation

By Emma A. Winslow, Ph.D.
Director of Research, Commonwealth Fund Child Health Demonstration

HOW much of a nurse's day will have to be spent in health centers, schools and homes in order to secure a desired output of service is a matter of much importance in public health administration. If her time is poorly distributed or it is assumed that she can do more than can possibly be squeezed within the limits of her working hours, there is likely to be either a sacrifice somewhere in the content of the service being rendered or a disappointment in the expected volume. If too little is routinely required, it is only human nature to limit output accordingly.

Obviously the amount which a nurse can do within a certain period of time is dependent upon her mental and physical capacity, the kind of nursing program in which she is engaged and the community conditions under which her work has to be carried on. As yet we are far from being able to measure with accuracy variations in activity output due to individual differences in nurses but a good deal of information is accumulating in various connections which gives promise that before long we will be able to estimate with a fair degree of accuracy how much service an "average nurse" can render in a specified program in a certain type of community.

As a contribution toward the formulation of certain norms for nursing activities special analysis has been made of the time and service records kept during a four-year period in the four child health demonstrations of the Commonwealth Fund.

The results of this analysis show certain important similarities and differences in the yearly time distribution of the average nurse in these widely separated communities and also in the number of visits of the various types which she makes per year and the number of minutes required per visit.

Before we can formulate detailed standards on service norms and their variations, we need much additional information as to the time distribution and volume of service per nurse in various programs conducted under various auspices in many different communities. Because of the importance of having service norms available for administrative use it is to be hoped that a number of summaries of this type will be made by nursing organizations in the near future so that norms can be prepared based on the pooling of extensive experience.

DEMONSTRATION NURSING PROGRAMS

The aim in the child health demonstrations has been to build up a strong and well staffed health department, functioning in close coöperation with the work of private physicians. From the beginning the nursing program has been an integral part of the health department organization. All nursing service has been completely generalized with each field nurse carrying full responsibility for health center, school and home visiting activities in a district with about 5,000 population and with varying amounts of volunteer assistance.

While the nursing programs in the demonstrations have followed the same general plan and have been under the same supervisory control, many detailed variations have been made in accordance with the needs of the local situation. The work of the nurses in the demonstration in Fargo, N. D., was done under city conditions entirely. In Clarke County, Ga., much of the time of the nurses was used within the city of Athens but a small surrounding rural area within the county limits made certain phases of their activities of a distinctly rural character. The demonstrations in Rutherford County, Tenn., and Marion County, Ore., were

mainly rural but the presence of the city of Salem and certain other closely settled sections in Marion County made part of the work of the nurses in this rural demonstration similar to that being done by the nurses in the urban demonstrations.

In addition to program adjustments due to working and living conditions in urban and rural communities, the somewhat different health problems requiring special nursing attention in the South, Middle West and Far West necessitated certain special modifications in general procedures. What was to be done under the demonstration program also had to be fitted in with what had previously been done in community health work and what it was hoped would be continued under local support after demonstration termination.*

YEARLY TIME DISTRIBUTION PER NURSE

As shown in Table 1, the average nurse in each demonstration was employed for about 2,200 hours a year including both time on duty and time away on vacation and sick leave.

If she were working primarily under urban conditions, as in Fargo or Clarke County, she spent about 1,100 hours (half of her time) for field service in health centers, schools and homes, and the remainder for educational and organization activities, office work, travel, vacation and sick leave.

If she had much rural territory to cover, as in Rutherford County and Marion County, she used about 900 hours instead of 1,100 hours for field service and a correspondingly larger amount for the related activities.

Expressing these yearly figures on a weekly basis and excluding her month's vacation with its freedom from assigned duties, we find that out of her total 42 hours on duty the urban nurse in the demonstrations had available about 22 hours a week for distributing among her field activities and the rural nurse had about 18 hours.

TABLE 1. TIME DISTRIBUTION PER FIELD NURSE PER YEAR COMMONWEALTH FUND CHILD HEALTH DEMONSTRATIONS

	Fargo, N.D.	*Clarke County, Ga.*	*Rutherford County, Tenn.*	*Marion County, Ore.*
Average hours employed per nurse per year	*2188*	*2204*	*2160*	*2274*
Hours for field service: Total	*1105*	*1074*	*840*	*910*
Health center	92	120	148	162
School	516	283	160	315
Nursing visits: Total	*497*	*671*	*532*	*433*
Maternity service: Total	*53*	*115*	*95*	*105*
Prenatal	29	47	53	24
Delivery	..	..	..	22
Postnatal	24	68	42	59
Child health service: Total	*293*	*231*	*264*	*167*
Infant	95	76	89	75
Preschool	106	37	121	23
School	92	118	54	69
Morbidity service: Total	*151*	*325*	*173*	*161*
Tuberculosis	30	124	54	26
Other communicable	31	75	74	43
Non-communicable	90	126	65	92
Hours for related service: Total	*1083*	*1130*	*1320*	*1364*
Educational and organization activities	158	163	165	300
Office	435	354	480	401
Travel	232	374	465	396
Vacation and sick leave	258	239	207	267

* For detailed discussion of demonstration programs and accomplishments see reports available for distribution through the Commonwealth Fund Division of Publications, 578 Madison Avenue, New York, N. Y.

While this is a difference of only four hours of field time a week, it is a sufficiently large proportion of total field time to account for a considerable difference in the volume of service to be expected from a nurse responsible for health work in a rural territory.

HEALTH CENTER AND SCHOOL SERVICE

Assistance at health centers during the time of the medical conferences for infants and preschool children required in the demonstrations an average of between two and three hours of nursing field time a week.

Average time for nursing service in school buildings varied more widely and in close correlation with difference in the type of school program being carried. In all the demonstrations the nurse assisted the school physician as necessary before and during the time of his examinations in the schools in her district. She also did a good deal of work at school, both with teachers and pupils, in assisting with arrangements for defect corrections and other matters related to the health supervision of referred cases. In certain instances she taught short units of health classes and always helped if emergency conditions arose in connection with communicable disease control.

In Rutherford County with its many isolated rural schools this program of nursing was all that was carried routinely within its school building, and an average of about four hours of field time was required per nurse during each week of the school year.

The school program in force in Clarke County required an average of about seven hours per week per nurse and that in Marion County about eight hours. In both of these demonstrations a regular schedule of daily assistance to teachers in the inspection of referred cases was maintained in all city schools but the program in the rural schools was limited to that described above.

In Fargo all the schools in all the nursing districts were city schools and were reached daily by the nurses for assistance to the teachers in pupil inspections. In accordance with a plan for school nursing procedure already in operation before the beginning of the demonstration the nurses also made home visits on request of the teacher to all cases of second-day absence where illness was suspected. As will be discussed later, this policy increased greatly the number of nursing visits to school children; it also affected considerably the time required of the nurse for work within the school building because of the frequent necessity for conferences with the teachers before and after these visits were made. A number of hours of school time was also used by the nurses each month for the weighing and measuring of all the children in the schools in their districts.

Under the Fargo program the average nurse used about eleven hours a week during the school year for service within the school building—nearly three times as much as the rural nurse in Rutherford County and nearly half again as much as the partly urban and partly rural nurse in Clarke County or Marion County.

AVERAGE NUMBER AND TIME OF NURSING VISITS

The number of hours for nursing service in the form of field visits to individuals depends upon two factors: the number of hours free for field time after those needed for travel and other related services have been subtracted and the extent to which this total field time is being drawn upon for health center and school service.

While the average nurse in Fargo and in Clarke County both used about 22 hours per week for field service, the difference in hours for school service described above left the Fargo nurse about 10 hours a week of visit time while the average nurse in Clarke County had about 14 hours free to use in this way. The Marion County nurse used 9 hours in visit time per week out of a total field time of about 18 hours and the Rutherford County nurse with a similar number of total field hours but a lighter school and

health center program could render service in the form of nursing visits during about 11 hours a week.

As shown in Table 2, variations in the number of visits made within these different periods of time were not always in accordance with what you would expect from the number of hours of visit time employed. For instance, the average nurse in Fargo made several hundred more visits per year than the nurse in Clarke County or in Rutherford County, but used a smaller number of hours; she more than doubled the number of visits made by the nurse in Marion County but used only a slightly larger amount of time.

TABLE 2. NURSING VISITS PER FIELD NURSE PER YEAR COMMONWEALTH FUND CHILD HEALTH DEMONSTRATIONS

	Fargo, N.D.	*Clarke County, Ga.*	*Rutherford County, Tenn.*	*Marion County, Ore.*
Average visits per nurse per year	*2487*	*2272*	*1904*	*1143*
Maternity service: Total	*174*	*352*	*248*	*150*
Prenatal	96	144	139	57
Delivery	..	..	..	10
Postnatal	78	208	109	83
Child health service: Total	*1780*	*981*	*1045*	*533*
Infant	424	316	332	166
Preschool	779	184	501	91
School	577	481	212	276
Morbidity service: Total	*533*	*939*	*611*	*460*
Tuberculosis	158	355	146	78
Other communicable	152	234	268	182
Non-communicable	223	350	197	200

One of the reasons for variation in output of visits in relation to total visit time is the difference in average length of visit reported for the four demonstrations (Table 3). This variation, however, is not as great as would be anticipated when you stop to consider differences in living conditions, in personal and community attitudes toward public health activities, and probably in the nurses themselves, in work organized among both colored and white in two southern counties, a city in the Middle West and a county in the Far West.

Prenatal, postnatal and infant visits tended to be about the same length in Fargo and Clarke County and only slightly shorter than those in the rural homes of Rutherford. Marion County

TABLE 3. AVERAGE MINUTES OF FIELD TIME PER VISIT COMMONWEALTH FUND CHILD HEALTH DEMONSTRATIONS

	Fargo, N.D.	*Clarke County, Ga.*	*Rutherford County, Tenn.*	*Marion County, Ore.*
Average number of minutes of field time per visit	*12.0*	*17.7*	*16.2*	*22.7*
Maternity service				
Prenatal	18.2	19.8	23.1	24.9
Delivery	....	....	....	139.5
Postnatal	18.8	19.3	22.7	42.6
Child health service				
Infant	13.3	14.5	15.9	27.2
Preschool	8.1	12.1	14.8	15.3
School	9.5	14.7	15.2	15.0
Morbidity service				
Tuberculosis	11.5	21.1	13.8	20.0
Other communicable	10.2	19.2	16.5	14.4
Non-communicable	27.3	21.5	19.9	27.5

was the only place where delivery service was provided or special emphasis placed upon the giving of bedside care on a fee basis in connection with the postpartum care of the mother and the newborn care of the child. This policy tended to make a much longer average time for both the postnatal and infant visit in Marion County although the average time for the prenatal visit was about the same as in the other demonstrations.

Except in Fargo the length of visits for the health supervision of preschool children and school children averaged about 15 minutes — very nearly the same as the visit to infants where emphasis was not placed on newborn care.

The lower average time for visits to preschool children and school children in Fargo was apparently due mainly to the local policy already described of having the nurses make home visits routinely as part of the school service in cases of second-day absence where illness was suspected. Often no illness was found and there was no particular problem in connection with the child's health supervision requiring detailed discussion in the home by the nurse. Under such conditions a very brief nursing visit is all that is necessary and this pulled down considerably the average visit time shown for Fargo in comparison with what would have been shown if only visits to school children with a definite content of health supervision had been included.

An important by-product of these many nursing visits to school children in Fargo was the making of many nursing contacts with infants and preschool children. Health records were opened for these children and visits were counted even when but little time was used in the initial service to the child. Frequently the result of these brief contacts was the visit of the child to the health center and the beginning of continued medical and nursing service for health supervision. In many instances, however, especially among preschool children, the child did not come under such supervision and the large proportion of visits with only brief content counted under the Fargo plan of procedure probably affected the average time for preschool visits in much the same way as the average time for school visits was affected by the large proportion of brief visits in the school service.

The average time per visit in the tuberculosis service was very nearly the same in both Clarke County and Marion County where it was demonstration policy to provide bedside care if necessary. In Fargo and Rutherford County this was done to a far more limited extent and only a relatively short visit time is indicated in their averages.

Noticeable differences are shown also in certain of the demonstration averages for visits in the control of other communicable diseases and in the non-communicable morbidity service. Here the longer and shorter visits are probably due both to differences in the policy as to the furnishing of bedside care and also to the nature of diseases prevalent in the local communities and the type of nursing care necessary for their control.

While these variations in time per visit explain certain of the differences in total visit time and total visits as shown in Tables 1 and 2, another important factor is the variation in proportions of visits requiring relatively long or short periods of time. For instance, Fargo's large number of visits and short visit time was due partly to the few minutes per visit in the preschool and school service and also to the large proportion of these briefer visits in relation to total visits. Marion County, at the other extreme, had both a long average time per visit and a very large proportion of visits of a type which included much nursing care and many minutes for completion.

Even with all these program differences, the range in average time used per nurse per week for the various types of nursing visits follows a somewhat similar pattern in all the generalized nursing services under health department auspices being developed in

the child health demonstrations. Between one and two hours a week was used in visits for maternity service. About two hours were used for visits to infants, one-half to three hours for visits to preschool children, and from one to two hours for visits to school children. Visits for tuberculosis prevention and control averaged from one-half to three-fourths of an hour a week except in Clarke County where the average hours for such service was increased to about three per week as the result of the special emphasis given to this work in the local program. Visits for other types of communicable disease control (including venereal disease control) took from about one-half an hour a week to about two hours. Visits in the non-communicable morbidity service required from one to three hours per week.

AVERAGE TIME FOR RELATED SERVICES

The educational and organization activities of the nurses, including time used for staff meetings, required an average of about three hours a week except in Marion County. Here much work in community organization was done by the staff nurses during the early stages of demonstration development and about six hours a week is shown as the average for the four year period although somewhat less has been used during the last part of the time.

Under office time was reported time used for work on records and reports, brief conferences with staff members or special visitors, and the many and varied jobs which the nurse has to do at her office headquarters if medical and nursing equipment and supplies are to be kept in shape for the work of the day. In Clarke County where an unusually large amount of clerical assistance was provided to the nurses in connection with the preparation and handling of case records and reports, office time was kept down to an average of about seven hours a week per nurse. In Marion County the nurses used eight hours a week; in Fargo, nine hours; in Rutherford County, ten hours.

In Fargo, a compact city, each nurse required about five hours a week of her time on duty for travel by foot and on street cars and motor buses, with periodically a certain amount of assistance in longer trips through the loan of the car of the nursing supervisor. In the other demonstrations each field nurse had an automobile for her personal use. In both Clarke County and Marion County the travel time per nurse averaged about eight hours a week and in Rutherford County about ten hours. The area in Marion County was far greater than that in the other demonstrations but travel time was kept low by the policy of having the nurses in charge of the more remote sections of the county live within their districts and maintain local headquarters instead of traveling back and forth each day from the central headquarters at the county seat.

As shown in Table 1, total time for vacation and sick leave averaged from about 210 to 270 hours per year per nurse. Demonstration policy was to allow a month's vacation a year, or about 180 hours of working time. This makes the sick leave allowance per nurse average 30 to 90 hours per year or from 4 to 13 working days. Included within the total time for sick leave are, however, several instances of long absence due to serious illness, and the average time per nurse for sick leave as here given probably runs considerably higher than the amount of time required by most members of the nursing staff.*

* This article will be followed in a later issue by one presenting the results of a special study of salary costs of nursing visits in the four demonstrations.

Among the Negroes in Southern Maryland

By Myrtle M. Patten
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CALVERT County, Maryland, is a peninsula some fifty miles long formed by the Chesapeake Bay and Patuxent River. The 15,000 inhabitants are nearly equally divided between the white and Negro races.

Establishing a colored nurse in this county was a part of the general plan adopted in 1927 of the National Health Circle for Colored People to place colored public health nurses in various southern states. Since this was a new field, one of the first objectives was to get as much publicity as possible. Church congregations and other public gatherings were visited and talks given to introduce this new health project and arouse the interest of the colored population.

Special Problems

In former years typhoid fever had been one of the worst scourges of this district, the low lands along the river and improper disposal of waste contributing to the spread of the disease. The low lands are no longer a menace, but the method of disposal of waste from many of the Negro homes is still far from sanitary. In June and July, 1927, seven cases of typhoid fever were reported in three families living about half a mile from the county seat. On investigation it was found that any idea of isolation was entirely absent. There were no screens and flies were taking full possession of the premises. After the first visit of the nurse, however, the people were willing to be cooperative, and in a few days screens were provided for the doors and windows, mosquito netting was placed over the beds, sanitary precautions were taken and visitors were excluded.

Tuberculosis

The County is credited with a large number of active and inactive tuberculosis cases. Most of those on file have been reported through the monthly Tuberculosis Clinics, held at the County Hospital. An exception was the case of a family reported by the preacher. In this family the husband had deserted soon after the last child was born, and since his desertion the family had been living in a hut approximately 10′ x 16′. A blind boy of 19 lay ill on a cot in the middle of the room, the only available space for the cot. Chairs, tables, trunks and baskets of clothes filled the space on either side. A full-size bed at the far end of the room and another cot near the door were for the use of the other six members of the household. In a corner a wood-burning stove, built for heating, served also as a cook-stove. The place was fairly clean but one needed a bridge to get to the stove or beyond the sick boy. He was very thin and complained continually of the pain in his "stomach." An older brother was coughing and spitting frequently. A younger one was almost blind and suffered from severe curvature of the spine. It was evident the services of more than one helping hand were needed.

The suggestion that the whole family be examined at the next Tuberculosis Clinic was agreed to by the physician and the preacher promised to see that they were brought to the clinic. "Far advanced pulmonary tuberculosis with a draining sinus of the left arm" was the diagnosis in Frederick's case. Application for admission to the State Sanatorium was made at once. Although the prognosis was poor, it was essential to get him away from the rest of the family. Two weeks later he was taken to the Sanatorium where he died within a month of admission.

None of the other members of the family had active tuberculosis, but it was imperative to get them into better quarters and a few weeks later they

moved to a four roomed house. Two members of the family have been examined since the death of the last patient and told that no active tuberculosis exists. Incidentally, the twelve year old boy has been treated for cataract at one of the city hospitals.

Fighting Diphtheria

It was thought that diphtheria would require a fight on general principles only, but its persistent occurrence makes an active campaign necessary. A boy came to the doctor with "just a sore throat." There was a membrane over the throat and a strict quarantine was ordered. It was soon apparent the quarantine was not being kept and five other clinical cases of diphtheria developed among school children. The entire school was carefully examined, suspicious throats were cultured, and antitoxin was given promptly. A preschool child developed laryngeal croup and was saved by being taken in the middle of the night for intubation at a hospital seventy-five miles away. Following up these cases and carriers meant weeks of work. Some cases were finally cleared up by tonsillectomies.

The anti-diphtheria campaign was the first work of the County Health Officer after he was put on a full time basis. This flare-up just described occurred in a school which last year quietly refused to sponsor the toxin-antitoxin campaign. Less than 4 per cent of the children were permitted to have T.A.T., while in most of the schools 70 per cent were given the three doses, and in one or two 100 per cent received the treatment, although it sometimes required as many as five trips to complete the treatments.

This year the children who had received T.A.T. were given Schick tests. In the school mentioned above where diphtheria occurred, all the children were subsequently given toxin-antitoxin, whether they wished it or not—though as a matter of fact, there was no opposition this time.

Smallpox is a disease which caused little concern among the colored people. The "Vaccination Doctor" in each district was asked to visit the school each year and vaccinate all children found not to have a satisfactory scar. It was necessary to vaccinate only the first graders each year. Prior to 1927 this was practically all that was even theoretically attempted in the twenty-one colored schools. When a nurse came who had time to weigh, measure, and inspect all the children, a large percentage of them was found who had never been vaccinated. The co-operation of the teachers was requested to see that no child without a scar attend school after the Health Officer's first visit. All through the year the war has been waged. This year an even stricter rule was put in force—"no child in school, even for a day, without having been vaccinated." How they poured into the Health Officer's office for the treatment!—children from 6 months to 16 years. The procession lasted well into the middle of the school year.

Physical Examinations

Since physical examinations in the schools by the Health Officer is a new project, instead of examining the first three grades only, all grades are examined. When defects are found a card is sent home to the parent telling of findings and urging correction of defects. Home visits are made to advise and plan for the correction of the most serious defects. When corrections are made the cards are returned to the nurse stating what has been done, signed by the physician. This gives some chance of checking the number of defects corrected.

The most prevalent defects are in the teeth, and as 95 per cent of the parents made no effort to visit the dentist, it seemed up to the public health authorities to take action. Dental clinics were started in 1928, beginning in the schools at the southern end of the county and working northward. It was impossible to cover all schools before they closed, so the most central points were visited, combining schools when possible and hav-

ing the children transported in the school bus. The dentist was a young man much interested in clinics for school children. Thirty-five cents a treatment was charged. In this project the coöperation was good. Consent forms asking for such service were sent to the parents, who signed and returned them.

Child Hygiene Conferences

With the school dental clinics, Child Hygiene Conferences are held to give dental treatment to preschool children as well as to their older brothers and sisters. The Child Hygiene Conferences were among the first activities of the program, having been initiated at the time of the Maternity and Infancy Act. Publicity is given by means of notes to parents, by posters, and by articles in the County papers. They are held monthly at a different place each month for six months, then repeating the schedule. In the summer of 1927, the nurses were in one continuous hustle for two weeks, assisting at the traveling Health Bus, which held clinics throughout the County. It was a busy time. Infants, preschool and school children were included.

In an effort to get the parents into the habit of having their children examined yearly, a note with recommendations is given the parent at the time of the Conference. Follow-up visits are made to urge the parents to carry out the recommendations.

Most of the prenatal cases are found only by chance. Occasionally a mother will send for the nurse, not for prenatal advice, but to ask for midwife services. She is then often in the last month of pregnancy. Of course the opportunity is used to give appropriate literature and the patients are particularly urged to engage a physician or licensed midwife as soon as possible.

Midwife Problem

Midwives are a problem. A survey in 1927 was made for the purpose of locating and identifying them. Many ranged in age from forty-seven to seventy-four years in age and were justly called "grannies." Nearly all were ignorant as well as untidy and dirty. Some with very poor eye-sight were taking cases even after their eyesight had failed. About 70 per cent of the mothers are attended by such midwives. The wonder was that our unsatisfactory death rates were not higher.

On the first tour of inspection birth certificates, birth report cards, and silver nitrate were left with each midwife. Those not licensed were cautioned not to practice without a physician in charge. They were instructed how to fill out certificates and cards and how to put drops in babies' eyes, and were told to send the cards and certificates within four days after births to the proper officials. The report cards come to the Health Officer, and are turned over to the nurse, so that she may make a visit while the midwife is still on the case. The ideal is to visit each baby, especially those delivered by midwives, during the first week of life, after six weeks, at six months, and at a year. If they are in good condition at one year, they are dismissed and put in the inactive file, with the hope that they can be got to the Child Hygiene Conferences.

Each mother visited has been urged to let the nurse know of the next pregnancy not later than the fifth month. One mother, who had been delivered of six babies, reported that all her children died within the first year of life. A Wassermann test was reported negative. Hospitalization was arranged for her next delivery, and she was glad to take advantage of it. This baby is doing nicely. It is to be hoped that this will be a beginning in getting mothers to come to the County Hospital for all deliveries. The mothers are being educated in the importance of proper care in the first week after delivery.

Besides educating the mothers in the care of themselves and their children, the most important job is to raise the standard of practicing midwives. For

them a general review of classes they had attended was given. Few came. For those who had no license but thought they could pass the examination, an examination was held. The highest mark was 63 per cent. Then a full course in midwifery was given with the hope of helping the unlicensed ones to obtain legal permission to practice, to train new ones. Only two unlicensed ones that had been practicing attended regularly. There was one new applicant. After a six weeks' course, the new midwife passed the examination and one of the others.

To get the old midwives to change their ideas of service is absolutely impossible. One midwife has been prosecuted for continuous practice without a license or physician—but she still goes cheerfully on. Release by death is the only solution here.

To have young, intelligent women trained as midwives would produce a reasonably safe situation; and it is hoped that from courses conducted every two years there may be graduated from each class two such women, who have a conscientious interest in the welfare of their patients.

STANDARDS OF HABIT FORMATION

The Infant Welfare Society of Chicago is preparing standards of habit formation which will follow rather closely the child's physical development during the preschool period. The ages at which various habits of adjustments are expected are based upon what has actually been found to be true in the study of a large number of normal children.

There are four or five outstanding health habits to be expected in each of the first few years:

By his first birthday the child may be expected to:

Drink from a cup and eat from a spoon (bottle discarded).
Sleep alone, without artificial soothing such as rocking, pacifier or bottle.
Have control of his bowels (when put on the nursery chair regularly, adult still taking the responsibility).
Be content with little attention.

(These are simple matters but the child who has mastered them has adjusted well to his first year.)

By his second birthday he may be expected to:

Feed himself with cup and spoon.
Sleep in a room alone—night and nap.
Have control of both bowels and bladder.
Have a dry bed at night.
Pull off his own shoes and stockings, hat and coat, or any article which does not require too much undoing.
Amuse himself alone with toys.

By his third birthday he may be expected to:

Eat his entire meal without help.
Undress himself.
Wash himself and brush his teeth.
Ask for the toilet. (This marks the shifting of responsibility from the adult to the child.)
Play well with other children. (This presupposes that he has been provided with playmates and a chance to work out his social life on a contemporary scale.)

By his fourth birthday he may be expected to:

Serve himself at table.
Dress himself and lace his shoes.
Comb his hair.
Wait on himself at toilet.
Put away his toys without being reminded.

By his fifth and sixth birthdays he should show greater skill and ease in all of these accomplishments and should assume responsibility for the regularity of his health habits. For example, at bedtime he may be expected to undress himself, wash, brush his teeth and go to the toilet without being reminded of each separate step. The child who meets these simple standards by the time he reaches school age will find himself well equipped to face the social situations which await him during the next few years.*

* From a radio talk by Dorothy E. Hall, Infant Welfare Society of Chicago.

Alabama's Health Program

With Special Reference to Public Health Nursing

By Jessie L. Marriner
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ALABAMA leads the States of the Union in the proportion of full-time county health units, having organized fifty-two of its sixty-seven counties. The statewide program of public health and preventive medicine has received, for many years, the hearty support of the people. One reason for this is the non-political character of the state health organization.

ORGANIZATION

Since 1875 the Alabama State Medical Association has, by legislative enactment, been the constituted health authority of the State. The Board of Censors of the Association consists of ten members of the College of Councillors, elected two each year for five years; this board operates in three different capacities, and under three separate names:

As the Board of Censors it is empowered to act for the Association in the interim between regular annual sessions.

Under the name State Board of Medical Examination and Licensure it serves as a legal agency for the regulation of medical practice.

When, between annual sessions of the State Association, it performs the functions of the State Board of Health, its official title is the State Committee of Public Health; to this body is added by law the governor of the state, as ex-officio chairman.

The State Health Officer is elected by the State Committee of Public Health for a period of five years, subject to the approval of the State Medical Association at its next regular session.

It has been the custom of the Board to continue to reëlect a competent health officer as long as he is successful in bringing about desired results. This provides an assurance of tenure of office sufficient to warrant the expectation of making it a life work. Such an expectation contributes greatly to the stability and usefulness of an organization unique in character, which has effectively removed state health matters from partisan politics.

The ex-officio chairmanship of the Governor has resulted in a better understanding of health needs on the part of the State's Chief Executive, and has enlisted the hearty coöperation of succeeding governors in the health program, as put forward by the medical profession. The moral and financial support of legislative bodies and the general public, follow in natural order.

AIMS OF THE HEALTH PROGRAM

To reduce the number of deaths from those preventable causes which incapacitate the greatest number of people and occasion the greatest social and economic loss.

To raise the level of health and well-being of all the people.

No other state has provided full-time health service for so great a proportion of its population (82 per cent). Every effort will be made to give 100 per cent full-time county health service within the next twelve months.

The Rockefeller Foundation has found that the major health problems in Alabama are those of practically every one of the semi-tropical countries in which it is engaged in coöperative undertakings. It naturally follows that Alabama is selected as one of the centers in this country for experimental work and research activities, an area in which plans of operation may be tested before being

recommended to other governments. Bringing representatives of other governments here for observation was the next logical step, and one that has in the past six years become almost a routine practice.

An average of 100 visitors per year, during the past three years, have come from Europe, the Balkan States, the Orient, England and her dominions, South America, Central America, the East Indies and the West Indies. Many of these visitors have been nurses sent through the courtesy of the Rockefeller Foundation to study Alabama's Rural Health Service with special reference to its public health nursing activities.

BUREAU OF PUBLIC HEALTH NURSING

Early in 1919 the State Board of Health established a Bureau of Public Health Nursing which in 1920 was combined with a Bureau of Child Hygiene and placed under the direction of a nurse. It is under the leadership of this Bureau, sustained and guided by the State Health officer, that a State program of public health nursing has developed.

The functions of the Bureau of Child Hygiene and Public Health Nursing as outlined by the State Health Officer are:

To serve as the administrative medium for all of the public health nursing activities of the State Board of Health.

To promote the development of public health nursing throughout the state.

To encourage nurses to take advantage of increased facilities for education in public health nursing.

To select and recommend candidates for positions.

To set up desirable standards of work.

To encourage local executives to determine administrative policies only after consulting with state advisors.

To coöperate in special efforts in public health nursing education.

To bring to the general public, and especially to the mothers and fathers of the State, a knowledge of the hygiene of maternity and infancy.

To promote the regulation of midwifery practice.

To bring to parents and others a fuller appreciation of the importance of the preschool age period and a more detailed knowledge of the hygiene of this period.

To bring to the general public and especially to the school forces of the state, a fuller knowledge and appreciation of the importance of school hygiene and of health education of the school child.

To render effective service in the development of a school health program, which shall be an integral part of the life, well-being and growth of the school system.

ACCOMPLISHMENTS

Its accomplishments since 1919 might be summarized as follows:

A state program of public health nursing has been defined, inaugurated, and established as a subsidiary activity of the State Board of Health. Counties having nursing activities have been increased from five to fifty-two, the nursing staff from five white and two negro nurses to eighty-seven white and twenty-three negro nurses. A basis of coöperation has been established between the State Bureau and other state agencies interested in child development.

During the entire period of operation of the Federal Maternity Act, April 1, 1922, to June 30, 1929, this bureau served as the coöperating agency for its administration in Alabama.

Staff education has been promoted by:

An annual conference of public health nurses.

Advisory visits of supervisors to the counties and visits of staff nurses to headquarters.

Correspondence.

Leaves of absence for further educational advancement.

Graphic representations of the county nurses' activities and distribution of her time.

HEALTH EDUCATION

At the request of the State Department of Education a study was made of health education work in the state normal schools. During one school year a special supervisor of health education was made available to the state Department of Education for an intensive health education campaign in seven selected counties. The services of a teacher of health education were given to Alabama College for Women

for two summer ssesions; to the University of Alabama for extension work in Jefferson County for two school years, and to the University of Alabama for three summer sessions. In these various ways several hundred elementary school teachers were reached with helpful health instruction, which included teaching methods.

Concurrent with these fragmentary activities was the development in the educational field of a clearly defined purpose to include credit courses in health education in all training institutions. This aim has reached its consummation in the State Teachers Colleges, while other institutions of higher learning have partially perfected plans for curricular expansion along health education lines. Four county boards of education have employed directors of health and physical education. One, the Jefferson County Board of Health, carries five additional supervisors of health education.

In coöperation with the county medical societies pediatric clinics were held for periods of one week with a pediatrician from Johns Hopkins in charge. These activities continued during two summers, 1925 and 1926, and served twenty county medical societies.

A maternal mortality study covering the years 1927–1928 has been completed in coöperation with the Federal Children's Bureau.

A roster of midwives shows 2,662 names. Free nitrate of silver ampules are furnished all midwives, and a carefully planned course of instruction with forms for granting permits is furnished county health officers for their use in supervising midwifery practice.

Future plans for the bureau include the extension of its advisory service to cover all county health units, and the development of its program of staff education to include quarterly district conferences.

MATERNITY AND INFANCY BILL

A maternity and infancy measure has been introduced in this 71st Congress, prepared by the Maternity and Infancy Legislative Committee of the Women's Joint Congressional Committee. The measure repeats in the main the provisions of the Sheppard-Towner Act.

While fifteen states (Delaware, Maine, Maryland, Michigan, Missouri, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, South Dakota, Tennessee, Vermont, Wisconsin) and the Territory of Hawaii appropriated funds equaling the combined federal and state aid of last year, many states are feeling the lack of federal funds, and public health work is suffering.

The essential features of the bill—known as the Jones-Cooper Bill—provide a $1,000,000 annual appropriation to be administered by the Children's Bureau and expended in states which match on a 50–50 basis the federal funds available. It is expected that a hearing will be held early this year before the Senate Committee to which these measures have been referred.

Iodin and the Thyroid Gland

By Martha Koehne, Ph.D.
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JUST as one cannot visualize the needs of the body for iron without studying hemoglobin and the red blood cells, so one cannot appreciate the place of iodin in nutrition without an understanding of the functions of the thyroid gland. The thyroid gland is a small, saddle shaped organ lying over the trachea. In normal adults having no thyroid enlargement it weighs from 26 to 30 grams, or approximately 1 ounce. According to Marine if the gland contains over 0.1 per cent iodin no goiter develops, but if it contains less than this amount enlargement will probably occur sooner or later.

Iodin that enters the body through food, water, skin, or air, is taken to this gland and there transformed, by the cells of the gland, into a substance known as thyroxin, containing 65 per cent of iodin. The presence of *normal* amounts of thyroxin in the general circulation is absolutely essential to well-being.

THYROID ABNORMALITY

The following outline, based on observations of Marine (1926), gives the principal forms of thyroid abnormality:

1. Graves' Disease represented chiefly by exophthalmic goiter and toxic adenoma. The cells of the gland are over-functioning and sending out excessive amounts of thyroxin into the general circulation.
2. Thyroid insufficiencies, of which there are two types—
   a. Myxedema, where wholly inadequate amounts of thyroxin are being secreted due to under-functioning thyroid cells. This may be a congenital condition in which case it is known as *Cretinism*, or it may develop any time during life.
   b. Simple goiter, associated with an inadequate supply of iodin available to the gland.

In the discussion which follows, special emphasis will be placed on simple goiter, for its prevention is a real public health problem in many parts of the world. Myxedema and toxic goiter will be discussed only to the extent of showing their interrelationship with and differentiation from simple goiter, with the outstanding characteristics of each.

SIMPLE GOITER

Marine (1926) states that simple goiter is found in all land and fresh water animals having a ductless thyroid gland. It is known in all races of people, living in all climates and at all habitable altitudes. There are certain regions of the world where it is found in a high percentage of the inhabitants, human and otherwise. These regions are the Himalaya Mts. of northern India, Alps Mts. of Switzerland, Andes Mts. and Peruvian Plateau of South America, Great Lakes Basin, St. Lawrence River Basin, and Cascade Mts. of North America. The Appalachian Mts., Cumberland Plateau, and Rocky Mt. states are not quite as severely goitrous.

Simple goiter is not a characteristic just of mountain country, nor of limestone regions and it is not necessarily prevented by living close to the ocean. Its incidence is greatest where the soil has been deposited from melting glacial ice. The percentage of people having goiter is always inversely proportional to the supply of iodin in the food and water in the locality. In a region where simple goiter is endemic among the people, dairy herds, pigs, poultry, and the fish in hatcheries are likely to show marked effects likewise.

Simple goiter is probably 2 to 3 times more prevalent among girls and women than among boys and men. It is a simple enlargement of the gland as a result of *relative* or absolute deficiencies of iodin in the body. According to Marine (1926) any set of conditions causing a complete change in the metabolism of a person and increased energy needs may temporarily

increase the body needs for iodin with which to manufacture thyroxin. If the iodin is not being supplied in generous enough amounts the gland may enlarge temporarily. This is termed *relative* deficiency of iodin.

The following circumstances of life will illustrate this point: puberty, especially if associated with very rapid growth, pregnancy, lactation, menopause, severe infections or intoxications. The food and water of the region may supply enough iodin for all except such people.

By *absolute iodin* deficiency is meant wholly inadequate amounts of iodin for the population generally. The four periods in life when goiter most frequently develops are: (1) fetal life, (2) puberty, (3) pregnancy and lactation, (4) menopause. Any plan that succeeds in preventing overgrowth of the gland at these periods will practically eliminate simple goiter.

McClendon in 1923 and 1924 made extensive analyses of the iodin content of food and water in various parts of the country—including sections where goiter was endemic as well as sections where it was seldom seen. He correlated his findings with the known incidence of goiter in these regions as shown in examinations of soldiers in the draft in the world war. The zones having the highest incidence of goiter had water supplies practically devoid of iodin. Sea water contains over one hundred times as much iodin as the average water from the zone having the least goiter. He obtained similar results with analyses of foods from goitrous and non-goitrous regions. In goiter regions he found milk, animal products, leafy vegetables, and fruits more dependable sources than water. In many fruits, however, the iodin is concentrated more in the hulls and seeds, and, unless these are finely macerated when eaten the iodin would be poorly utilized. The significance of the presence or absence of iodin in drinking water lies more in the evidence it gives of its presence in the soil from which the water came and in which vegetation grows than as an adequate source of iodin in itself. The average person cannot drink enough water to supply his iodin needs even in those regions where it is present in the water in significant amounts.

Tressler and Wells as a result of their analyses of sea foods in 1923 conclude that oysters, clams, and lobsters contain 200 times as much iodin as beefsteak or milk, shrimp 100 times as much, crabs and most ocean fish 50 times as much. Marine algae rank highest of all but are not used as food in this country.

As early as 1820 Coindet advised using iodin in the treatment of goiter. The early Greeks treated goiter by giving patients the ash of burned sea sponges. As a means of prevention, however, iodin was first used by Marine and Kimball (1921) in work done with school children in Akron, Ohio, beginning in 1917. That effort spent in preventing goiter is worth while is evidenced by the fact that its elimination will *prevent almost all* other forms of thyroid abnormality (probably not Graves' Disease). Cretinism with its associated ill effects and toxic goiters are much more prevalent wherever the incidence of simple goiter is high. Adenomas, which so frequently develop toxic properties later in life, can be prevented.

METHODS OF GIVING IODIN

Oleson (1924) gives an excellent summary of methods of giving iodin for the prevention of simple goiter.* Iodin is readily taken up by the thyroid when given by inhalation, by external application, or by mouth.

1. *By inhalation.* Wide mouth bottles containing tincture of iodin are suspended in a warm room. The vapor from this solution carries particles of iodin into the air that is breathed. The method has been used with success but is impractical because of inability to regulate dosage.

* It is unnecessary to remind nurses that administration of iodin in any form should be only under a physician's order.

2. *By external application.* Painting with tincture of iodin often causes blistering of the skin. There are too many pleasanter and easier ways to give iodin to make this method necessary or advisable. Other iodin ointments have been used with success. Applications may be made any place on the body. It is not necessary that they be rubbed on the gland itself. Again, however, it is hard to regulate dosage by this means.

3. *By mouth.*

a. Sodium iodide tablets (3 grains) were dissolved in a glass of water for each child each day for ten days in spring and fall, in Marine and Kimball's Akron experiment. The only disadvantage is the disagreeable taste of the water.

b. *Chocolate coated Iodostarine tablets,* each containing 5 to 10 milligrams (0.005 to 0.010 grams) iodin, were originally made in Switzerland. These are tasteless, pleasant to take, and keep indefinitely. The favorite way to use them is to take one a week for 40 weeks (the usual length of the school year) or each week during pregnancy and lactation. The goiter commission of Switzerland recommends this method throughout the country in all schools and it is used extensively in many goiter regions in this country.

c. One cubic centimeter of sirup of hydriotic acid and ferrous iodide may be given daily for 2 or 3 weeks, spring and fall. Some prefer to give 1 drop for each year of age, daily, during alternate months.

d. *Iodized table salt,* containing .005 to .01 per cent sodium iodide is having a wide vogue now in goitrous districts. The advantages of this method are:

Everyone will be reached, for all people use salt in their food. Used in this way it is not regarded as a medicine as are the tablets. The expense is negligible. Some goitrous communities are considering making its use compulsory through forbidding the sale of uniodized salt.

On the other hand some physicians object to this method of administration because it increases the iodin intake of everyone, without medical supervision.

In those parts of the country where goiter is seldom seen in the native population iodin prophylaxis can very well be individualized and its use limited to those whom their physicians believe should have it. Public prophylactic measures are unnecessary and inadvisable.*

Oleson (1928) states that iodin used in treating existing goiters may be a two-edged sword. When used injudiciously either in large doses or in the wrong kind of goiter, it may inflict irreparable harm. *Only the well trained and experienced physician* should undertake to *treat* existing goiters. Uncomplicated simple goiter, if taken in time, can be cured by iodin treatment in the hands of a competent physician.

e. Iodized drinking water. Rochester, New York, iodizes the public water supply for two weeks twice a year. They try to provide, during these periods, water containing at least 50 parts iodin per billion parts of water. Sault Ste. Marie, Michigan, has adopted a similar plan. This would insure each inhabitant a definite supply of iodin. Time only will tell, through repeated surveys, how effective this method is. Since only 1 per cent of a public water supply is used for drinking, this may be a more extravagant way to administer it than iodized salt. Any possible objections to the general use of salt would apply equally to an iodized water supply.

MYXEDEMA

When families have lived for several generations in a goitrous district, children are frequently born who have thyroid glands that are incapable of manufacturing thyroxin even when

*** For a discussion of this readers are referred to two editorials in the *Journal of the American Medical Association,* one "Goiter Prophylaxis in Non-goitrous Areas," Vol. 86, June 26, 1926, p. 1394, and the other, "Limitations of Goiter Prophylaxis," Vol. 89, July 9, 1927, p. 114.**

iodin is supplied in adequate amounts. According to Lusk (1924), "Lack of thyroid secretion in the young results in undergrowth of the bones, dwarfism, cretinism, lack of muscular power, and undeveloped sex glands which are also functionally deficient." Edema develops. There are high grade cretins and low grade cretins, depending upon the degree of mentality. Wherever a community contains a number of cretins, the incidence of deaf and dumb mutism and idiocy is also high. Prevention of simple goiter will greatly reduce such conditions in time.

When a thyroid gland is too completely removed in goiter operations, or when it is destroyed by X-ray therapy, or when it spontaneously degenerates as a result of infection, a similar condition may develop in a person of any age. Mental degeneration follows, there is marked edema, the sex organs cease to function, and there is loss of muscular power and vitality. This is true myxedema. In both cretinism and myxedema there is a definite slowing up of energy-producing processes. The rate of basal metabolism may be reduced 40 per cent below normal.

Iodin therapy has very little effect in such cases. The treatment consists in giving dried thyroid gland of animals, or extract of this gland, or thyroxin. Such cases are purely *medical problems* and *must not* be prescribed for by nurses or lay people who are interested.

TOXIC GOITERS

No effort will be made to discuss the problem of differentiation between Exophthalmic Goiter (Graves' disease) and Toxic Adenoma. Even expert medical authorities differ in their ideas. Suffice it to say that in both cases we are dealing with a gland whose cells have increased, and are working over-time, causing excessive secretion of thyroxin. This results in a condition the exact opposite of myxedema. All processes in the body involved in transforming food into energy are speeded up. The rate of basal metabolism may be 75 per cent or more above normal. This causes in turn an enormous appetite with often actual loss in weight in spite of the amount of food consumed. The writer observed one patient who, while in bed in a hospital waiting for operation ate regularly for several weeks 3,800 to 4,000 calories each day yet lost weight. Such patients are extremely nervous, often resembling chorea patients. They seldom have fever but radiate off a great deal of heat. Sometimes there are mental hallucinations. The heart is seriously affected, respiration and pulse are very high.

Before leaving this subject it is well to discuss briefly the problem of certain patent anti-fat remedies available to the general public. If any such products are capable of accomplishing weight reduction without food restriction it is usually because they contain desiccated thyroid gland. As stated in the discussion of myxedema, the taking of thyroid extract will raise the rate of metabolism. We have also seen that if too much thyroid secretion is available in the general circulation, it exerts a definitely toxic action, and greatly increases the rate of oxidation of food stores in the body. The indiscriminate use of thyroid tablets will bring about loss of weight but *at serious risk to the heart and general health.* The effect is in many respects the same as if the person had a hyper-functioning gland. *No one* should *ever* take or recommend that another person take thyroid gland preparations except under the closest supervision of a competent physician.

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A Suggestive Efficiency Scale

After preliminary experimentation at the University of Michigan, Stanford University, and the University of North Carolina, a special committee of the American Council on Education has settled upon a form of personality rating for intensive study, which we quote from *Industrial Psychology* (September, 1928), thinking that the points hold valuable suggestions for supervisors. For *student* substitute the word *nurse*.

Significant features of this rating scale are "Only traits observed by the rater should be rated; only traits for which no valid objective measurements are now available should be rated; the number of traits to be rated should not exceed five, if teachers are to be expected to rate the traits of a large number of students; traits should be mutually exclusive; a trait should not involve unrelated modes of behavior."

PERSONALITY RATING SCALE

Tentative Form for Experiment

(The information on this sheet is confidential)

Name of Student

How does his appearance and manner affect others?
- Avoided by others
- Tolerated by others
- Unnoticed by others
- Well liked by others
- Sought by others
- No opportunity to observe

Does he need constant prodding or does he go ahead with his work without being told?
- Needs much prodding in doing ordinary assignments
- Needs occasional prodding
- Does ordinary assignments of his own accord
- Completes suggested supplementary work
- Seeks and sets for himself additional tasks
- No opportunity to observe

Does he get others to do what he wishes?
- Probably unable to lead his fellows
- Satisfied to have others take lead
- Sometimes leads in minor affairs
- Sometimes leads in important affairs
- Displays marked ability to lead his fellows; makes things go
- No opportunity to observe

How does he control his emotions?
- Too easily moved to anger or fits of depression, etc.
- Unresponsive, apathetic
- Tends to be over-emotional
- Tends to be unresponsive
- Usually well balanced
- Well balanced
- Unusual balance of responsiveness and control
- No opportunity to observe

Has he a program with definite purposes in terms of which he distributes his time and energy?
- Aimless trifler
- Aims just to "get by"
- Has vaguely formed objectives
- Directs energies effectively with fairly definite program
- Engrossed in realizing well formulated objectives
- No opportunity to observe

How well do you know this student?

Signature

Date

Position

Address

Rural Hospitals as Health Centers *

By Mary K. Nelson
Franklin County Memorial Hospital, Farmington, Me.

THE last United States census, taken in 1920, shows a rural population of over 51,000,000 or about 2.8 per cent less than the urban population. In *The Survey* of October 15, 1928, we read "More than 80 per cent of the rural population is as yet unprovided with official local health service 'approaching adequacy'."

The limited health facilities of the vast rural districts is one important obstacle to the better distribution of the nation's total population. Surprising facts are revealed when a comparison is made between urban and rural health reports. The magnitude of this nation-wide problem is evident when we realize how slow the progress has been in the last fifteen years.

The rural hospital is one of the most valuable aids in the solution of this difficult question; these small hospitals when adequately staffed, and equipped with facilities for prompt and accurate diagnosis and treatment, serve as health insurance provisions for their respective areas. The different agencies engaged in the extension of health service to rural areas, are already increasing the limited number of such hospitals.

The Hospital as a Health Center

First in order of consideration, we will take the rural public hospitals found in the seventeen states where laws providing for such county hospitals have been passed. The first such law was enacted in Iowa in 1909, and though the war delayed the movement somewhat the present number of county rural hospitals has greatly increased the value of the health program in their respective counties.

Such hospitals, supported by taxes and subject to political control, cannot give what the community hospital does give to the people of the area it serves. The reason is obvious, the people assume the community hospital responsibility in response to a need which they understand. This direct relation to the hospital from its beginning and the continued support which follows, prepare them to learn more and more of the health value of its service to the community. With this growing knowledge there is found an increasingly intelligent use of the hospital and its different services.

The friendliness of the community hospital is no small detail, but rather a very important asset; patients and their families learn health lessons under impressive surroundings, and the necessary personal contacts greatly add to the value of the future of this work.

The Hospital and the Schools

A close relation between the hospital and the health program of the widely scattered public schools is an important factor for consideration. Here we might picture these little schools spread over our great country, many of them as yet the only possible centers for health in their localities. We view the splendid work of the many hundred county and local public health nurses, who would gladly see these schools become sub-stations for a central health service station, a community hospital. They can appreciate how such a connection between school and hospital will afford the present children the opportunity of acquiring a high estimate of the hospital's value to their health and to the health of those about them. Such an attitude of our coming generation would mark an important constructive phase in the future service of rural community hospitals. As it functions, with regard to in-patients and out-patients, the hospital proves its value. The group

* Presented at the Congress of the International Council of Nurses, Montreal, Canada, July 12, 1929.

work of the physicians results in benefit to the present and future patients and to themselves in their work.

For rural nurses group effort is an inspiration even if only in the form of regular hospital contacts and conferences. The corrective work for children comes early to the attention of all. The good laboratory and isolation service provides a valuable check on communicable disease. The community problem of venereal disease can be assumed by the hospital. Its facilities which make possible earlier diagnosis and treatment of cancer, and organic diseases, form an increasingly important part of its service. Efficient care of accidents in this day of travel is another of its health provisions.

SPECIAL SERVICES

Leading the others is the maternity service. The problem of the pregnant mother without medical attention at birth cannot be solved without this hospital service. Rural nurses doing infant welfare work will gladly welcome the establishment of more community hospitals with their facilities for prenatal, maternity and postnatal services.

In rural homes, the care of the sick and the attention to the convalescent is not only a pressing need but a remarkable teaching opportunity. The hospitals with nurses for home follow up and bedside work are able to give complete health service to their communities, but the usual way of meeting this need is by close coöperation between county and local public health nurses and the hospital.

An outstanding example of the rural hospital health center is the Greater Community Hospital in Creston, Iowa. Here, beginning with a five bed hospital, such a large health project was gradually developed that the hospital has become a modern medical center where large numbers of doctors and nurses get their preparation for future work while serving a very considerable area surrounding the present large hospital. Some years ago, in an address given before the American Hospital Association, the Superintendent of the Creston Hospital said, "the coöperative participation of community forces in behalf of the community health, is the key to the rural health problem. County Medical Society team work in coöperation with public health nursing in agricultural sections will demonstrate the necessity for hospital facilities and the average rural community will do its part." The Greater Community Hospital is a story of coöperation that includes the community, the medical and nursing group, and all local and county health agencies.

Many rural communities need assistance in getting the hospital established. The Commonwealth Fund has a Division of Rural Hospitals and the Duke Endowment has a Hospital Section; both were recently created to help with this rural hospital problem. The hospitals with which they are connected will, in the next few years, have an opportunity to work out more definite ways by which hospitals can serve as health centers for their communities.

The community hospital health centers in our Southern mountain districts grew out of public health work which often started with a single public health nurse and a distant church group of interested workers. The Holman Hospital in Altapass, North Carolina, is an example of such development. These hospitals make a strong personal appeal because of the necessary missionary character of their work for communities otherwise unable to finance such an undertaking.

Dean Goodrich, speaking at the Hospital Association meeting several years ago, summarized the community needs of the different services in the hospital and concluded by saying "all these things demand that the hospital, of strategic importance in health problems, function either as a health center within a given area, or at least as a definite link in the chain of health activities required for a community health project."

Interrelationship of Visiting Nurse Service and Hospital

Henry Street Visiting Nurse Service and St. Mark's Hospital, New York City

IN the reorganization of St. Mark's Hospital, New York City, in 1926, the Henry Street Visiting Nurse Service was asked to establish a branch office in the new Dispensary and Ward Building. St. Mark's Hospital, on the corner of Second Avenue and Eleventh Street, is directly across the street from quaint St. Mark's-in-the-Bowerie, on the site of the chapel built by Governor Stuyvesant for the little Dutch Settlement that had sprung up around his farm. But that region ceased to be rural years ago and is today one of the most thickly populated areas in the world. It is (to quote a bulletin of St. Mark's School of Nursing) a cross section of the people of all countries and offers a fertile field for public health and hospital service.

The plans for the new building included model housing for a nursing center. The building was finished and Stuyvesant Center of the Henry Street Visiting Nurse Service was established there, February 11, 1927. The hospital wished to serve the community in a health educational and preventive as well as curative program and looked to the Visiting Nurse Service to form the connecting link between the hospital and the community.

To make coöperation between the out-patient department, the social service department and the nursing service physically convenient, rooms for the Henry Street center were assigned, opening out of the main hall of the out-patient department, with a swinging door into the social service department, so that the social service worker could say with real truth, "It is impossible to tell where social service ends and Henry Street begins." The main room occupied by the center is on the front of the building which faces south. This insures all the sunshine New York can provide. Cheery yellow walls, green furniture and attractive posters give the room a friendly appearance. One must feel healthier just to go there. In this room, the nurses do their office work. It is also used for health classes and other meetings. Opening out of it are a rest room, a small service room, where simple food can be prepared for use at mothers' meetings and a conference room.

ADMINISTRATION

A Joint Advisory Committee was formed, consisting of the Medical Director of the hospital, the Superintendent of Nurses, the Chairman of the Social Service Committee, the Director of the Social Service Department, the Director and Educational Director of the Henry Street Visiting Nurse Service, a lay member of the Nursing Committee, the Supervisor of the Stuyvesant Center and the Director of another hospital Social Service Department. This committee decided all questions of policy in the development of the new coöperative project, meeting once a month at first, and later several times a year, when called for special problems or reports of progress.

The Director of the Social Service Department is an ex-Henry Street nurse and her assistants have also had public health training. One of her chief functions is to serve as a clearing bureau in referring cases and exchanging information between the Hospital and the Henry Street Visiting Nurse Service. The Henry Street Center functions as any other Henry Street Visiting Nurse Service center, taking such cases as might be carried in any district.

COÖPERATIONS

Calls, in which the primary problem is health, are received by the Visiting Nurse Service. The Hospital agreed to pay the Henry Street Service

for the first contact in the home on all cases reported (exceptions were made in the case of patients covered by insurance companies). Henry Street returns to the Social Service Department a written report of the first visit. A record of these calls and visits is kept in the Stuyvesant Center and at the end of each month a bill is presented to St. Mark's Hospital for the visits charged to them during that month.

clinic, interviews the patient upon admission to the clinic; prepares the history for the doctor; confers with the patient regarding general hygiene. She is present at the doctor's examination and summarizes his findings and recommendations.

The agency referring the case for examination is held responsible for follow-up work on the patient. The necessary reports and correspondence regarding clinic attendance and return

REPORT TO SOCIAL SERVICE DEPARTMENT

NAME ADDRESS FL. CODE

Date reported

By what clinic referred Date visited Center

Condition for which referred

Care and advice given

Factors which relate to Health of Family: (intelligence, economic, housing, etc.)

Disposition of case (to be carried by H.S.S.—no care needed—referred to Social Service Agency, etc.)

Is patient insured?
M.L.I.
J.H.I. Nurse's Name

The Henry Street Visiting Nurse Service agreed to furnish a public health nurse for teaching purposes in a limited number of the St. Mark's Hospital clinics. The hospital pays for the time of the nurse during the clinic session. The Health Guidance clinics, Pre-Natal and Neurological clinics are staffed in this manner.

Several of the other clinics are under the supervision of nurses who have had public health training either with Henry Street or with the East Harlem Nursing and Health Service. These nurses are assisted by student nurses and are responsible for teaching in the clinic and for the selection of cases for home visiting.

HEALTH GUIDANCE SERVICE

The clinics in the Health Guidance Service offer health examinations to individuals between the ages of two and fifty-five, in sessions divided according to age groups. The clinic is managed on the appointment service and cases are referred by various agencies or by individual requests. The Henry Street Visiting Nurse in the clinic, interviews the patient upon admission to the clinic; prepares the history for the doctor; confers with the patient regarding general hygiene. She is present at the doctor's examination and summarizes his findings and recommendations.

The agency referring the case for examination is held responsible for follow-up work on the patient. The necessary reports and correspondence regarding clinic attendance and return examinations are managed by the Social Service Department. Consultations regarding individual cases are also handled by the Social Service Department and appointments made for the worker to interview the doctor when necessary.

Henry Street is likewise responsible for follow-up work on all cases which it refers to this service. In addition Henry Street is occasionally requested to assume responsibility for cases which are unable to secure adequate follow-up from any other source. A complete report of the examination is transferred to the nurses' history.

MATERNITY SERVICE

Henry Street and the out-patient department of the hospital coöperate still more strikingly in the prenatal clinic. This is held once a week. The Henry Street nurse has a separate room to do urinalysis and hold individual conferences with the patient concerning hygiene of pregnancy and preparation of supplies. The physical examination is made by the doctor who is assisted by hospital nurses. After the examina-

tion, the patient again returns to the Henry Street nurse to discuss the doctor's findings and recommendations. She is invited to attend the Mother's Club meeting which is held at the Henry Street office (the same nurse who works in the prenatal clinic is in charge of the mother's club). Routine home visits are made on all prenatal patients registered in the clinic and reports are sent to the hospital.

St. Marks has a large number of maternity patients and the hospital has taken pride in furnishing the delivery rooms with the most modern equipment for helping the patients. A keen personal interest is taken in each mother and her baby. This is illustrated by the plan of having all mothers go down to the Henry Street office the day before they leave the hospital for instruction in the care of their babies. The nurse in charge shows them a simple basket fitted out for the baby to sleep in and also the proper clothing and supplies for the new-born baby. They are instructed in the technique of the baby's bath. They are also given advice regarding the value of fresh air, loose clothing, and sunshine. They ask qustions freely, discuss the methods suggested and describe their own favorite proceedings or those of their friends.

NEUROLOGICAL SERVICE

The Neurological clinic is very closely linked up with the mental hygiene program of the Henry Street Visiting Nurse Service. Many of the cases referred to the Neurological clinic present interesting mental hygiene problems. The Henry Street nurse in the clinic takes the patient's history, is present at the doctor's examination and after consultation with the doctor, summarizes the findings and recommendations. Cases enrolled in this clinic are referred to Henry Street Visiting Nurse Service for home follow-up and are closely supervised by the mental hygiene supervisor on the Henry Street staff.

ALLOCATION OF DUTIES

Duties of the Social Service Department

Conference with all new patients before registration.
Take Social History.
Arrange Hospital Fees.

Refer all new cases to proper Henry Street Office for follow-up. (Abnormal cases in Brooklyn may be referred to the Brooklyn Visiting Nurse Service.)

Record on Henry Street cross file cards the date of admission to hospital and the date of delivery.

Interview patients before discharge from the hospital, taking calls for cases which are reported to Henry Street or the Brooklyn Visiting Nurse Service for post-partum welfare supervision.

Arrange for visit of patients to the Henry Street Office for conference before discharge from the hospital.

Record report of home visits from "St. Mark's Report" on Clinic chart.

Duties of the Henry Street Nurse in the Ante-Partum Clinic

Has conference with all patients attending clinic, preferably receiving new patients first.

Takes T.P.R., does urinalysis (tests for sugar on new patients), and ascertains any complaints, reporting such to the clinic doctor with the report of urinalysis, before he examines the patient. (If urinalysis is negative, the report is given to the clinic nurse after clinic and she is responsible for recording it on the clinic chart.)

After examination, explaining special advice or recommendations to the patients and if necessary, reports to the Henry Street nurse carrying the case.

Discusses diet, clothing, prenatal care, invites to Mother's Club and explains the Nursing Service.

Give out literature, display posters or demonstration material.

Make out Henry Street cross file cards, which are then given to Social Service for reporting of new cases to proper Henry Street Office for home supervision.

Send out cards to patients when post-partum examination is due.

Notify Henry Street nurse if her case is not attending clinic or when patient has been admitted to the Hospital.

Record on Henry Street cross file cards the date of first home visit from the St. Mark's report of nurse making the home visit and then give this report to the Social Service Department who records visit on clinic chart.

Instruction to Maternity Ward Patients

Conference and demonstration are given on the Care of the Baby before dismissal from the Hospital. This conference is given by the Supervisor or Nurse in charge of the Mother's Club.

Home Follow-up of Post-Partum Cases

All post-partum cases may have home supervision by the Visiting Nurse Service until the baby is one month old, if they so desire. These cases are reported to the Social Service when making the rounds in the Hospital and the first visit is again paid for by the Hospital if the case is not known to the Visiting Nurse Service.

Similar routines allocating responsibility and outlining procedures have been prepared in the other clinics.

See also for further description of this coöperative plan: *A Health Center in a Hospital—A Community Experiment*, by Margaret Lovell Plumley, *The Modern Hospital*, May, 1928.

NOMINATIONS FOR OFFICERS AND DIRECTORS OF THE N.O.P.H.N. SCHOOL NURSING SECTION

Suggestions will be welcomed by the Nominating Committee of the Section for names of officers and directors to be elected at the Biennial Convention. Suggestions should be sent to the Chairman of the Nominating Committee, Miss Beatrice Short, Indianapolis Visiting Nurse Association, Indianapolis, Ind. For your convenience the present officers of the Section are listed here:

Chairman—Ann Dickie Boyd, Denver.
Vice-Chairman—Mary E. Chayer, Des Moines.
Directors—B. B. Randle, Olean. Term expires 1932.
Elma Rood, Nashville. Term expires 1932.
Anna L. Stanley, Providence. Term expires 1930.
Lay Director—Dr. Anna Bailey, Berkeley. Term expires 1932.
Nurse member—Flora Burghdorf. Term expires 1930.
Non-nurse member—Grace Abbott. Term expires 1930.

The Effect of Prenatal Care Upon the Infant*

By Clifford G. Grulee, M.D.
Clinical Professor and Head of the Department of Pediatrics,
Bush Medical College of the University of Chicago

IT is perfectly obvious that the primary function of prenatal care is and must always be directed towards the care of the mother; her health is the thing of first importance. Nevertheless, it has been felt that such care would have a very beneficial effect upon the offspring. When we assume that the health of the mother presupposes the health of her unborn child, we are taking a position which is probably correct in part, but not definitely proven. We have some reason to raise this question because we know that unfortunately there are born to women, who are apparently in perfect health, deformed and deficient infants. One need only mention mongolian idiocy.

The question of the effect of prenatal care on the infant should be approached from two angles: first, the main effect; and second, the remote effect. Our knowledge of the physiologic and pathologic conditions of the fetus is almost altogether lacking, and with this failure in our knowledge we now grope along empirically attempting to use such scientific facts as we now possess. The first test of the effect of prenatal care will probably be its effect on neonatal mortality. In spite of the fact that much of the mortality in the first few days of life depends upon obstetrical care, it seems not unfair to expect that prenatal care will bring about a reduction in this mortality.

NEED FOR STUDY

The most enlightening statistics from this country are those of Holt and Babbitt. The first statement calls attention to the imperative necessity for the study of disease at this age. They state that out of 100 infants' deaths occurring in the first year, approximately 33 occur in the first month, 28 in the first two weeks, 22 in the first week, and 13 on the first day. This study is made on a total of 10,000 births, 253 were abortions, 429 still births, and 9,318 living.

An analysis of various other statistics shows that the vast bulk of deaths at this age occurs as a result of prematurity or congenital debility. For instance, in the Baudelocque clinic from 1901 to 1908 there were 345 deaths in the first 10 days of life. Of these, 275 were due to congenital debility (prematurity), 32 to syphilis, 10 to hemorrhage, 5 to digestive troubles, 6 to pulmonary troubles, 4 to icterus and 3 to erysipelas. This group probably represents a fair list of those conditions which are met with sufficient frequency to claim our immediate attention. When we analyze, however, the cause of congenital debility, we find the chief item consists of "unknown causes" 60 per cent, and that twins and triplets account for 15 per cent more, which means that in the present state of our knowledge 75 per cent of the cases of congenital debility are from unknown causes or from conditions over which we have no control. If we further analyze the remaining fourth, we find that 8 per cent or about ⅓ are due to disease of the mother, of which tuberculosis is most prominent, and such conditions as anemia, nephritis and heart disease are worthy of mention. It would seem that the only way to overcome mortality from these sources in most cases would be to prevent conception. Nor does the next group, consisting of 4 per cent, offer much better chance, since this group is caused by habitual premature labor. We see, therefore, that almost exactly ⅞ of our cases of

* Paper presented before the Child Hygiene Section, American Public Health Association Annual Meeting, October, 1920, Minneapolis, Minn.

congenital debility are from causes which, in the present state of our knowledge, are beyond our control. The two chief causes in the remaining groups are gynecological conditions, such as placenta previa, and syphilis. We have come to conditions which should be, and are, relatively easy to master and it is in one of these, syphilis, that we get the best results from prenatal care. Acute infections of the mother, eclampsia, trauma and induction of labor, are conditions in which at least we may hope to get better results.

When we turn, however, from the premature to the deaths of infants at term, the picture is decidedly brighter. There is no question but that prenatal care has materially reduced the chance of death from syphilis in offspring. The chances of success are materially increased the earlier in pregnancy the mother applies for prenatal care. It may be said that we cannot expect, in the present state of our knowledge, to reduce the deaths from congenital malformation. The other conditions, hemorrhage, digestive and pulmonary troubles, icterus—can be little influenced by prenatal care.

Is the chance of success in reducing infant mortality by prenatal care quite as small as would seem to be indicated by the foregoing analysis? I think not.

HOPEFUL OUTLOOK

There are some outside factors which a simple analysis of statistics from obstetrical clinics do not bring out. First and foremost, prenatal care means, in all probability, better obstetrics. The man who follows his patient through the period of pregnancy is much more likely to prepare himself to meet the problems of confinement more intelligently. Again, it seems altogether likely that our efforts to promote the health of the mother will meet with some unexpected successes for which we cannot account at the present time. And third, and by no means least important, such care will stimulate scientific effort to investigate the problems relative to the newly-born infant and the fetus.

In conclusion, I might beg you to withhold your judgment regarding the effect of prenatal care for a period of years. The problems to be solved are neither so obvious nor so easy as those we have had to meet in reducing infant mortality; and success can be expected only after long years of earnest and persistent study.

The Sub-Committee on Public Health Nursing of the American Public Health Association Committee on Administrative Practice is focusing its attention on the possibility of having some qualitative as well as quantitative measure of nursing service, gathering material relative to the merits or demerits of the various systems of administering school nursing, and material relative to the function and the administration of public health nursing in state departments of health.

The program of coöperation with the General Federation of Women's Clubs carried on for the past three years has received considerable attention during 1929, with profit both to the Association and to the Federation.

The Field Director was made a member of the Advisory Board to the Division of Public Health, Child Welfare and Community Service of the Public Welfare Department of the Federation, and has assisted in the planning of a health program covering community studies, health institutes, and general education in the field of maternal hygiene.

For the entire report of this Committee see the *American Journal of Public Health and The Nation's Health* for January.

A Modern Outlook

The Nurse as a Coördinator of Home and School

By M. Elizabeth Hazard
University of Washington, Seattle, Washington

WE have but to recall the history of public health nursing in America to remember that the school nurse came into existence only after the need of follow-up work in the home became apparent. It was primarily her duty to hasten the child's return to the class room by teaching the family to carry out the physician's instructions in the care of the child who had been excluded for physical reasons.

In that early day the teaching of health as well as home visiting was done by the nurse, requiring much of her time to be spent in the class room. To-day, however, educators recognize the importance of teaching health, not as an isolated subject, but as a part of the school curriculum — hence, it is taught by the class room teacher. With this present day program the nurse is released, more and more, from class room activities, thus enabling her to carry on more fully the home visiting phase of the program.

That the school nurse has long since proven the value of home visiting from the health point of view, is, in a measure, demonstrated by the following: A few years ago in an eastern community a survey, primarily to determine the value of the follow-up work done by the nurse in the home, was made of a group of school children who had been previously examined and their physical defects recorded. The result showed that the physician's recommendations had been carried out in 89 per cent of the cases which had been followed up by the nurse, while only 24 per cent were carried out in cases where no follow-up work had been done.

In no phase of public health nursing is the interrelation between health and social problems so apparent as in the field of school nursing. The nurse finds she cannot cope with health problems in the family without also handling social problems. This interrelation is recognized in other countries as well as in America, for Dr. J. C. Thomas in *Social and Health Work in London Schools,* says:

> "A country's educational system is in itself its greatest work for social amelioration. Health and education should advance together, and there is no other department of State activity so wide as the school. . . . It is hoped the day will come when English Boards of Education will be able to employ a sufficient number of trained public health nurses to take care of the school social service."

THE NURSE'S FIRST VISIT

The school nurse's first visit to the home is usually necessitated by the presence of a health problem with the child. In making this first visit she lays the foundation for success or failure in her future relationships with the family. Her personal interest and contact with the child in school generally serves as an entering wedge into the home. However, with the difficult family, even this will sometimes fail; but the alert nurse is never deterred in her efforts to establish friendly relationships with the family.

Many times a nurse is instrumental in winning coöperation between the school and the home where it had never previously existed. Even by influencing the parents to visit the school for the first time, she has been enabled to procure a helpful contact; then, one by one the barriers are broken down, and a friendly relationship between the parents and the school exists, which is always conducive to the child's happiness and social welfare.

In identifying herself with a family the nurse assumes the rôle of counsellor and friend, frequently finding problems of great importance, from the point of view of the family—

trivial though they may seem to her. In her wisdom she grasps this opportunity to assist in making adjustments, even though it seems much valuable time is spent in the process. In our own personal relationships, are we not just a little closer to the person who understands and helps in a time of anxiety? So it is with the family, and the wide awake nurse, during this process of adjustment, is constantly making the most of her opportunity—and step by step is enabled to lay a firm foundation for the health program she ultimately aspires to develop within the family.

When a child enters school he is in an entirely new world. During the period of adjustment to this new situation many problems present themselves. Frequently he is referred to the nurse as a health problem, when, upon investigation, she finds the difficulty is not physical but a mental or social maladjustment. Fully appreciating the vital significance between social maladjustments and health problems, she here has a golden opportunity to stem the tide of future behavior difficulties by effecting coöperation between the home and the teacher.

THE CHILD'S BACKGROUND

When we realize that a relatively small portion of the child's life is spent in the school, and that his personality is molded largely within the family group, we then more fully appreciate the need of a knowledge of his environment. The teacher may be able to interpret the child, but she cannot, through the child, interpret the home.

Realizing the significance of social factors, we cannot deal fairly with the child without a knowledge of his social and cultural background. With her knowledge of the family in all its aspects, the nurse is prepared to interpret the home to the teacher. How often the attitude of the distraught teacher changes toward a child when she gets an insight into his home and family relationships, and the intimate side of his life is revealed to her. By the nurse's constant efforts to improve the standard of healthful living conditions in the home, results manifest themselves through the adjustment of many behavior problems which once existed in the life of the child.

ADJUSTING THE ADOLESCENT

Upon reaching adolescence the child again enters a new world. Here a more complex social situation confronts the nurse. She finds more difficulty in effecting an adjustment than with the younger child. In the present day tendency of disregard for parental authority, the nurse is called upon to interpret parent to child, as well as child to parent, in order that each may have a more rational appreciation of the other's viewpoint.

In the broken home situation the nurse again plays a most important part. It is often her duty to interview both parents regarding a health or behavior problem of the child. At the first approach, more frequently than not, she is told of the other's misdemeanors, and it is here that in her judgment and understanding she may be able to so present the case of the other, the condition of the home as it now exists, and the detriment to the child's progress because of this condition—that an adjustment can be brought about for the best interest of the child—which, in another way, releases him for the upward trend to good citizenship.

Every educator, every social worker, in fact every person interested in public welfare, can most heartily agree with Herbert Hoover when he says:

> If we could grapple with the whole child situation in one generation, our public health, our economic efficiency, the moral character, sanity and stability of our people should advance three generations in one.

But realizing that it is impossible to "advance three generations in one"—it becomes the job of the school nurse to carry on from day to day, teaching the gospel of a "Healthy, vigorous mind and body for every child—a preparation for the future leadership of our country."

A Project in Staff Education

A Study of Racial Groups

By Elizabeth Hanson

Tuberculosis Supervisor, Visiting Nurse Association, Inc., Hartford, Conn.

THE problem of staff education is how to arouse and stimulate within the worker, herself, the urge for such information as will enable her to gain a larger perspective, to broaden and make more intelligent her sympathies, and consequently to give greater service. This is especially true in the field of tuberculosis.

With this as an objective the staff of the Hartford Visiting Nurse Association, in connection with the weekly specialized tuberculosis round tables, is carrying out a project which is bringing most interesting results both from the point of view of apparent enjoyment and of stimulation to further reading. This project is a study of the various nationality groups with which we have to deal here in Hartford.

PLAN OF STUDY

The supervisor obtains an analysis of the city's population and lists the nationality groups in order of size. Each member then chooses and studies a group developing her theme to her own satisfaction, though the suggested general procedure is as follows:

First, the nurse chooses the group in which she is most interested, which is often that from which her own people came, thereby making the added contribution of personal interest.

Second, she obtains from the public library, or elsewhere, the best available references.

Third, the discussion is given, in general, from the standpoints of:

A brief history of the race.

General characteristics of the racial group, such as, does this people cling tenaciously to its old traditions or does it adapt itself rather easily to its new environment?

Its general, or special contributions to civilization.

Application, that is, in view of what has been learned, can early results with the group be expected or must all efforts be tempered with unusual patience?

Fifteen minutes of each weekly tuberculosis round table is given over to this type of education. So far the Irish, the Polish, the Negroes, the Jews, the Canadian French, and the Italians have been studied.

STUDY OF THE NEGRO RACE

Of tremendous interest, for example, was the discussion of the Negro race by one of our colored nurses. In brief, her theme touched upon the struggles of the newly emancipated race just following the Civil War; the problems of the government in trying to meet so serious a situation; the political issues involved; the development and the present status of Negro education; the economic status and its relation to the health of the race, especially as regards the tuberculosis death rate; the contribution of the race to America along the lines of music, poetry, and dancing.

The discussion of the Negro group was the first one presented and has been carried as far as an analysis of our colored patients and their families. The tuberculosis death rate for the colored people in Hartford for 1928 was 410; the death rate for the white people was 58. Not only bad, but tragic! The analysis was made as to number of patients, average age of patients, age range, average number in families, birthplace, average length of stay in Hartford, range in years of such stay, and number of such patients twelve years of age or less. The same tabulation was made for the "contacts." If there is sufficient available data, an analysis as to occupation will be made also.

Such analyses enable us to rate ourselves, using the Appraisal Form as a basis for the rating. With facts such as these at our disposal and the active interest of the group, it will not be impossible, perhaps, to take steps toward "doing something about it."

OTHER GROUPS

Equally interesting have been the discussions of the other groups; the Irish with their history of struggles for objectives which they consider essential to happiness; the Canadian French with their language handicap, for many of them have come from parts of Canada where French only is spoken; the Jews and how history has affected them and their progress, and the Italians with their particular problems.

How far the project will develop cannot be predicted at present, but it is expected that it will lead to further activity. The greatest value of the project, of course, lies in the nurse's application of the information gained and in her appreciation of the importance of the emotional side of life in peoples with whose history and traditions she may not be very familiar. Of immeasurable satisfaction is the stimulation to thought through further reading and the revelation to the nurse, herself, of the possibilities within her grasp of a greater knowledge of the many factors in the larger aspects of human welfare.

REVIEW OF STAFF EDUCATION, LOWELL, MASS.

Staff education in a Visiting Nurse Association is not a fad or fancy but proves its value in producing more intelligent and efficient workers. Our meetings in Lowell, Mass., aim to help the individual nurse acquire useful knowledge, to impart that knowledge to others and to give each nurse an opportunity to hear her voice in public. Our most important purpose is to give better care to our patients.

I shall summarize what we accomplished in 1929.

Review of nursing magazines each month.
- *The American Journal of Nursing.*
- THE PUBLIC HEALTH NURSE.

Review of books.
- "Nurses, Patients and Pocketbooks."
- "The Healthy Child from 2 to 7 Years."
- Improvised Equipment in the Homes—Olsen.

Review of special articles.

Demonstrations given by nurses.
- Prenatal visit.
- Delivery in the home.
- General care.
- Baby Hygiene visit and demonstration of formulae.
- Pre-school visit.
- Communicable disease technique.
- Technique of enemas, douches, and irrigations.

Miscellaneous.
- Records and record keeping.
- Open discussion of management of a district.

Lectures—Outside speakers.
- Delivery and Obstetrical Technique.
- Feeding and general care of infants.
- Nutrition of the School Child.
- Work of the Lowell Social Service League.
- Social Hygiene.
- Work of the Girl's City Club.

Six nurses attended a course of evening lectures given by the State Department of Public Welfare and every member of the staff attended the lecture on Mental Hygiene in this course.

Reports were given on visits made to Perkins Institute for the Blind—Massachusetts State Infirmary—and reports were given on the lectures heard at the New England Health Conference held at Hartford, Conn.

From October, 1928, to June, 1929:

Total time spent in staff education—841 hours.

Number of conferences—67.

Average number of times each nurse participated—3 7/10.

Total time spent approximated about 40 per cent of one nurse's work and was equal to about $580.00.

The nurses met each Wednesday morning for the regular staff conference. It was decided to have a short meeting on Friday mornings also. This program was adhered to throughout the year, the only exception that was allowed by the

Chairman of our Program Committee, was when more than one nurse had been out on delivery service the previous night.

These meetings have given us an opportunity for group discussion, each nurse was invited to bring constructive criticism to the meeting. Sometimes the reviews, when they have dragged on and on give us the point of view of the mothers of our families who must sometimes wish we would be gone and let them get to their housework!

The discussion which followed the review of our staff education brought out the following points:

Many of the nurses had improved in speaking before the group.

The important points had not always been emphasized in review—it was suggested that each nurse should summarize by using an outline form.

The advisability of having our meetings at four o'clock in the afternoon was discussed and it was voted to continue our morning meetings during the next year, because of the generalized program we carry and the difficulty in planning time off duty.

A new staff nurse asked if our Board of Managers knew how much time was given to Staff Education. The effect of staff education in making a more contented staff as well as a staff nurse more intelligent about the work of the organization was mentioned.

The nurses thought the participation of each nurse in the program was valuable.

All of the nurses voted for the continuance of our meetings.

The fact that all of our nurses do not read the nursing journals was brought out.

Teresa M. Hayes, R.N., Visiting Nurse Association, Lowell, Mass.

REPORT OF THE COMMITTEE ON COMMUNITY CHEST STANDARDS

Included in the Proceedings of the Third Annual Institute for Social Work Executives at Blue Ridge, North Carolina, is a committee report on Community Chest Standards which will be of interest to all who are willing to indulge in a bit of self-criticism of a constructive sort. The report is an attempt to set out what a Community Social Work Federation (Chest and Council) should do, how it should be organized, and who should be its executive.

"This report," says the introduction, "resulted from what was perhaps the first joint attempt of representatives of various types of social agencies to render an opinion on the best type of Community Chest organization, the functions of a Chest, and the qualifications of a Chest executive. Because the report represents the consensus of opinion and carries the approval of 20 representatives of Chests, 13 representatives of national agencies, and 38 other local and state agencies, who attended the Institute, should it not be regarded as having some real significance to the Chest movement? Unquestionably it deserves the most critical study." The report follows:

Proper Functions of a Community Social Work Federation in a Local Community

To develop team work

BETWEEN

Social agencies, executives, social workers, board members, constituencies, persons who give service, persons who give money, civic, religious, and fraternal organizations.

FOR

Discovery and appraisal of social needs, building an organization program in form and function to meet these needs (a) as they confront the individual agency, (b) as they confront the coöperating agencies. Building public support in terms of social concern, understanding and action, and finance, for example

Contributions to community chests.
Endowments to public or private agencies.
Tax support for public agencies.
Fees for services rendered.

Community budgeting within the combined campaign, without the combined campaign, in relation to public departments.

Specific Planks in Relation to the Joint Finance Function

The safeguarding of the individuality of member organizations
- No arbitrary interference with the internal policies of member organizations.
- No assumption by federation of operative social work functions.
- Encouragement of the maintenance of interested groups for the member organizations.

The careful fulfillment of mutual obligations between organizations in the interest of the joint movement
- Certain recognized standards of endorsement.
- Exchange of full information about finances and social program.
- Participation in joint discussion and planning activities.
- Participation in the joint finance campaign.
- Participation in the program of publicity and education of the public.

The assumption by the local federation officials of responsibility for
- Leadership in the organization and execution of the finance campaign.
- Leadership in joint planning activities.
- A good business administration, including a fixed fiscal year, a sound system of collection of pledges, full payment of finally approved allowances to agencies if required under the approved budget and program, a public audit of central office and member organizations, and a systematic collection and compilation of service figures.
- Leadership in a method of budget study for setting finance goal and apportioning funds which will combine the best judgment of the member agencies and of the contributing public.
- Leadership in educational publicity.
- Utilization of special studies and surveys as a guide to program, campaign goals, agency income, distribution of funds, and experimentation.

—*News Bulletin, November 15, 1929—Association of Community Chests and Councils.*

LEADING ARTICLES IN THE AMERICAN JOURNAL OF NURSING FOR FEBRUARY

When Your Children Have Measles Don't Keep Them in the Dark*

By B. Franklin Royer, M.D.
National Society for the Prevention of Blindness, New York City

To Avoid Eye Complications During Measles

1. **Banish fear of light in the measles sickroom.**
2. **Seek eye comfort with adequate light and an abundance of fresh air.**
3. **Strive for extreme cleanliness.**
4. **Place the head of the child's bed toward the window.**
5. **Arrange artificial lighting equipment so that during the few hours that artificial light may be required no possible glare may annoy the patient.**
6. **Follow out the physician's directions to the letter.**

PROBABLY more harm has been done by the old-fashioned notion that the child with measles must be kept in a dark room than by any other single nursing fault. The fact that the tears are flowing and the eyes are a little congested is not a sufficient reason for putting the child in a dark room. In no other disease of childhood are fresh air and good light so imperative in treatment.

Nearly all the later editions of textbooks on children's diseases declare that open windows and fresh air are imperative, and some of the recent publications even feature the fact that a dark room is undesirable; but even those physicians who specialize in children's diseases have seemed a little hesitant about entirely disregarding the fear of light notion passed on from their grandmothers.

Bacteriologists have perhaps not put enough stress on the fact that the pneumonia germ and other germs commonly found associated in measles grow best in darkness or semidarkness. Darkening of the room is a procedure that may become a real menace to the eyes because of favoring the growth of the germs of greatest danger to the eyes. *Let the daylight in.*

THINGS THAT MAY BE DONE

Probably there is nothing so soothing and comfortable in the early stages of measles when the eyes are inflamed as the laying on the eyes for just a few minutes at a time of little pledgets of cotton that have been taken from cool water. In an early stage of measles it is inadvisable to use long-continued cold or ice-cold applications.

If pus is seen in the corners of the eyes at any time in measles, the most careful cleansing is advised. A boric acid solution, 3 per cent in strength, in freshly boiled or distilled water heated to the temperature of the body may be ordered. First wash the lid margins until every bit of soilage is removed from the lashes and skin, or squeeze the drops of boric acid solution from the cotton and flush them over the eyeball and inside the separated lids. The head should be turned first to one side and then to the other so that by no possible chance can the material that is washed out of one eye flow across the bridge of the nose and into the other. A different piece of cotton should be used for each eye and for each procedure. The hands should be thoroughly washed before and after taking care of one eye before touching the other. The entire nursing procedure must aim to avoid trailing infection.

Dry eyes and dry lid margins and lashes require the most skillful care. With some measles patients, when tears are not flowing well, it becomes necessary to irrigate the eyes frequently; often ointment must be pre-

* Abstract from an article which originally appeared in *Hygeia*. Reprints of the whole article may be obtained from the National Society for the Prevention of Blindness, 370 Seventh Avenue, New York, N. Y.

scribed for the lid margins because nature's oily secretion is not being properly provided during the fever. The doctor often orders soft, moist cotton compresses frequently applied for short intervals, in addition to the irrigation.

POSITION OF BED

As nearly as possible the head of the child's bed should be toward the window. This will give light in the child's face without the direct rays striking the eye in such a way that they cause pain. If there should be too much tearing with the head in this position, it is a simple matter to place a dark screen near the head of the bed, or a simple eye shade on the forehead, if the child is not annoyed by it.

LIMITING BOOKS AND TOYS

The use of the eyes for close vision should be minimized and parents should be warned of the danger of giving the child books and toys that permit him to use his eyes at close range longer hours every day than if he were well and out at play.

These precautions should be observed for a period of a month or six weeks after the child's recovery.

SCHOOL "SPACING" DURING MEASLES OUTBREAKS

Dr. Robert Hughes, M.O.H., Stoke-on-Trent, considers that closure of elementary schools during an outbreak of measles is not only useless, but harmful in that it destroys the only means of discovering cases. On the other hand, "there is no doubt that early exclusion of suspects, exclusion of home contacts, 'spacing,' 'dilution' by immunes (mixing with the non-immune susceptible children, known to have been rendered immune by previous attack) and strict attention to ventilation constitute the best of all expedients for curtailing an outbreak of measles in a classroom. Yet I have frequently found, on visiting such a classroom, that instead of being spaced out, the children remaining are all huddled together. The popular clamour for disinfection of school classrooms on account of an outbreak of measles, if complied with, only puts the authority to utterly useless expense. Measles is contracted from persons, not from things."—*The Nursing Times.*

BIENNIAL CONVENTION ANNOUNCEMENTS

Glenn Frank, President of University of Wisconsin, will be the principal speaker at the opening meeting of the Biennial Convention of the Three National Nursing Organizations Monday evening, June 9th, in Milwaukee. Dr. Frank, whose ability as a gifted speaker is widely known will be followed by representatives of the city and state who will welcome the nurses to Wisconsin.

Following the meetings of the boards of directors of the three organizations which are being held as this copy goes to press, it is expected that further program subjects and speakers will be announced.

A number of nurses attending the convention are planning to visit the Rochester, Minnesota, clinic and hospitals while they are in that part of the country. If there are enough requests for the trip, a special train will be run to Rochester, and a program will be arranged for a post-convention day, probably June 14th. Nurses wishing to visit Rochester are asked to notify their transportation chairman, or Headquarters, 370 Seventh Avenue, New York City.

ACTIVITIES *of the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, INC.

Edited by KATHARINE TUCKER

PUBLICITY

The N.O.P.H.N. has two new publicity devices available for distribution: an attractive poster and a folder of information.

The poster shows the public health nurse instructing in the home with the interested members of the family about her. This poster has been drawn by a well known artist, is set up on heavy drawing paper and may be obtained either in black and white or in soft colors. There is no printing on the poster, thus making it convenient for local use. It is sold for 50 cents a copy, with reductions in price for orders of ten or more. This poster is recommended to local organizations for such use as distribution in financial campaigns, announcements of new services, announcements of clinics, etc.

The new folder appears in a spring green cover and is entitled "National Organization for Public Health Nursing, Inc.—What it is and what it does." It gives a concrete statement of the purposes and particularly of the services rendered by the N.O.P.H.N. This folder is available for free distribution.

EDUCATION COMMITTEE

A new type of efficiency form for public health nurses is being developed as a project of the Education Committee of the N.O.P.H.N. A group of public health nursing supervisors taking work at Teachers College have taken 35 sample efficiency forms and are analyzing the thirty-odd items which have been used to describe public health nurses. Instead of answering the question "what kind of person is a nurse?", the new form tries to answer the question "what does she do?" Particular emphasis is also being placed on brevity.

INDUSTRIAL NURSING

In order to acquaint industrial organizations and industrial nurses with the fact that the N.O.P.H.N. is now prepared to offer service to industrial groups—through consultation, institutes for nurses and publications in the magazine—letters have been sent to the Departments of Labor and Industry in all of the states, to the Presidents of State Organizations for Public Health Nursing, Chairmen of Public Health Nursing Sections, Presidents of State Graduate Nurse Associations and Presidents of Industrial Nurses Clubs. Mrs. Hodgson, who is devoting a large part of her time to industrial nursing, is glad to be called on for advisory service.

SOCIAL HYGIENE

The American Social Hygiene Association, through its Division of Medical Measures, for some time has sent to Health Officers at regular intervals letters, graphs and pamphlets dealing with the different phases of venereal disease control. Particular emphasis has been given to the prevention of congenital syphilis. Through the joint project of the N.O.P.H.N. and A.S.H.A. this service is offered to nursing organizations that indicate a desire to receive it, Miss Moore being the particular staff member assigned to this part of the work.

The initial stages of the joint project will consist in learning what social hygiene programs at present exist in local organizations, this information to be gathered at the time of the N.O.P.H.N. salary study. An advisory service will

be offered to these organizations and will be extended to communities wishing to initiate new social hygiene programs as requests develop.

The A.S.H.A. plans to send a letter to its affiliated organizations announcing the project and possible field trips of Miss Moore. Simultaneously the N.O.P.H.N. will make similar announcements to the local public health nursing organizations concerned.

A number of national lay organizations such as the Federation of Women's Clubs, the Parent Teacher Association, and the Child Study Association, are active in various phases of social hygiene work. Miss Moore is in touch with such organizations to consider possible coöperative schemes.

The educational services of the joint social hygiene project will eventually include suggestions for programs for staff education, outlines for institutes and assistance in conducting them, suggestions for speakers, compilation of bibliographies and the study of the curricula on social hygiene subjects both in undergraduate and post-graduate courses for nurses.

Miss Moore has recently prepared a tentative outline on Social Hygiene and Sex Education to be incorporated as part of the staff education program in the Minneapolis Visiting Nurse Association. It is interesting to note that the staff nurses themselves originated this request. Copies of this plan may be obtained from the N.O.P.H.N.

SERVICE TO BOARD AND COMMITTEE MEMBERS SECTION

Miss Davis is giving consideration to the health programs of a number of national lay organizations with special reference to potentialities for coöperation between these organizations and the Board and Committee Members Section of the N.O.P.H.N. She spoke on the Responsibilities of Board Members at both an Institute for Board Members and at a local nursing committee meeting.

FIELD SERVICE

"Newer Trends in Public Health Nursing" was the subject of a talk given before the Council of Social Agencies in Orange, N. J., by Miss Tucker. The audience included a large group of social workers, as well as public health nurses, not only from Orange, but from Montclair and neighboring cities.

In December, Miss Moore made a brief survey of the Nursing Service of the Bureau of Venereal Diseases, Syracuse, N. Y., at the request of the Commissioner of Health. Suggestions were made relative to certain changes in the local situation.

At the request of the Federation of Social Service, Elmira, N. Y., Mrs. Hodgson made a two day study of the Visiting Nurse Association, resulting in definite recommendations regarding organization plans. This visit was actually a follow-up of the original study made of this organization in 1926 and gives evidence of the value of returning to a city some years after the first study to advise regarding the original recommendations in relation to subsequent local changes.

Mrs. Hodgson also spoke to the nurses of Westchester County on "The Technique of Records and the Nursing Visit" and observation visits were made to two local industrial establishments.

WHITE HOUSE CONFERENCE

It is interesting to report that the N.O.P.H.N. is well represented both through its staff and its members on a number of sub-committees of the White House Conference, especially those in which nursing plays an integral part. This brings to attention the many ramifications of nursing throughout the variety of health and social service activities in this country.

DELIVERY AND HOURLY APPOINTMENT SERVICE

Do you need information on delivery and hourly appointment services? Why not write the N.O.P.H.N. the next time you want information instead of writing directly to the organizations carrying these services? The N.O.P.H.N. has collected and just brought up to date statements from 25 organizations. A folder with all the 25 statements may be had as a loan by writing one letter to the N.O.P.H.N. The new folders are ready now.

BOARD AND COMMITTEE MEMBERS' FORUM

Edited by VIRGINIA BLAKE MILLER

Board Member, Instructive Visiting Nurse Society, Washington, D. C.

Scholarships, Loans, and Leaves of Absence *

By MARJORY STIMSON
Assistant Director, N.O.P.H.N.

FOR a subject of such wide interest as that of "Scholarships, Loans, and Leaves of Absence," there is very little printed. Hardly a week passes that someone does not write to the National Organization for Public Health Nursing to know what organizations offer opportunities for part-time work and study and what post-graduate courses have scholarships and loan funds. Directors of Public Health Nursing courses ask whether it is for financial reasons that more students are not registered for study. Graduate nurse associations wish to know what other states are doing to raise loan funds for nurses whom they wish to develop as leaders. Board members wonder whether they have failed in their duty because their local association has no endowment for loans or scholarships. Because of these queries it seems worth while to assemble the facts which we have gathered from questionnaire, correspondence, and news bulletins.

RETURNS FROM QUESTIONNAIRE

Early in 1928, information was received by the N.O.P.H.N. from 114 public health nursing organizations in the United States on the subject of their staff educational programs. Questions were asked as to whether provision was made for scholarship or loan funds; whether extension courses were available for the staff; whether these courses were taken on the orgnaization's or the nurse's time, and paid for by the organization or by the nurse; what opportunities for post-graduate study or experience were open to supervisors and field nurses and what the policy of the organization was as to salary allowance while such work was carried on.

Twenty-eight official and 86 non-official public health nursing agencies answered the questionnaire. The fact that no official agencies offered scholarships or loans was to be expected, but it was interesting to discover how few of the 86 non-official agencies had made such provision. Only 6 reported *scholarship* funds and only 4 had *loan* funds, with 2 organizations reporting that they hoped to have funds in the near future. Since these questionnaires were received, the N.O.P.H.N. through the Forum and other sources has news of 6 additional funds.

The prevailing practice seems in favor of the flexible arrangements possible in granting leaves of absence. Many of these are granted with salary which in reality amounts to a "scholarship" or, if granted without pay, there is a subsequent raise in salary.

Of the official agencies which reported a policy on leaves of absence, 5 were in localities where no extension courses were available, but in one place a course in nutrition had been arranged, and in another, special arrangements were made with a local university for courses partly paid by the nurse and partly paid by the organization. Five other city departments had been able to allow their nurses time off duty to take special courses, although the nurses had to pay the fees. Three allowed part of the

* See also an article in the January *American Journal of Nursing*, "Loan Funds and Scholarships."

organization's time for lectures. Apparently the benefits from well organized study off-set the loss of time, even to organizations which are traditionally limited in their educational efforts by the close scrutiny of the taxpayers.

Among the non-official agencies, 49 stated a definite policy regarding leaves of absence; 9 paying for extension courses which were given on organization time and 16 not paying the fee, but allowing the time for the course. Twenty-five other organizations stated that extension courses were available to their staff, but these were taken on the nurses' own time.

LEAVES OF ABSENCE

Leaves of absence for the regular post-graduate courses are also a rather general practice. Two official groups reported their supervisors were allowed salary during leave, depending on their length of service and value to the department. Four others had granted supervisors leaves of absence at different times. In the case of field nurses, two organizations reported that positions were kept open and salary increased on return. Another stated that opportunities for summer study with salary were offered staff nurses. Eighteen of the 28 official agencies gave no information on this subject of post-graduate study.

Among the 86 non-official agencies, only 31 stated a policy on leaves for supervisors. Two allowed leave with and 6 without salary, 3 reported leave allowed, but did not specify salary arrangement, 5 reported that their policy depended on the individual and 15 had practices which varied from allowing one week's observation with salary, to allowing all expenses and salary for summer courses. Several of these organizations allowed a limited amount of time for courses given in local educational institutions, the general practice being to specify the number of credit-points which could be taken on organization time. One place allowed as much as two afternoons a week on organization time with salary. In the case of field nurses, 37 organizations stated a policy with practices which varied as widely as in the case of supervisors. One board allowed certain nurses tuition and salary for a course in physiotherapy. Another allowed two weeks in addition to the month's vacation in order that field nurses might take summer courses.

INFORMATION FROM REPORTS TO THE FORUM

Due to the interest in such aids to staff education, Mrs. George Brown Miller, Editor of the Board and Committee Members Forum, has written a number of organizations for further information. During the past year she has received letters from a number of the presidents of Public Health Nursing boards. The following quotations indicate the individual adaptations made in different cities:

Indianapolis Public Health Nursing Association—

> The organization allows one hour a week if the class is given at 4:00 P.M. The courses are paid for by the nurses themselves. There is provision for small scholarships.

Pittsburgh Public Health Nursing Association—

> Opportunities offered supervisors to visit and observe other organizations or public health nursing demonstrations. Salaries are allowed during this time. The scholarship fund is $250.00 a semester.

Richmond Instructive Visiting Nurse Association—

> At present we are offering an extension course to our staff nurses on organization time, using the hour for weekly conference for these classes. This course is being paid for by the organization. Any nurse who has been with our organization for one year and is desirous of taking some post-graduate work at the School of Social Work and Public Health is given an extra afternoon a week for such studies. We have no provision for scholarships or loan funds, but have been considering this question for some time.

Nashville Public Health Nursing Council—

> Each staff nurse is permitted to take one course (four credit hours a week) on the organization's time, if the hour at which the class meets does not interfere too seriously with the day's routine. This means that she is usually able to enter only such classes as meet at 8:00 A.M. or

4:00 P.M., the beginning or end of her working day. This, however, makes it possible for her to take two of the most important courses—Principles of Public Health Nursing, and Maternal and Infant Hygiene. The nurse pays her own tuition at the college. Staff nurses and supervisors who wish to devote full time to study are granted a leave of absence, usually without salary, in order to do so.

Toledo District Nurse Association—

We give a maximum of six nurses the privilege of taking one hour's class work a week at the Toledo University on the Association's time. This year the Association paid the fees for three of these workers. In addition 20 nurses are attending evening classes at the University or the High schools. We have no provision for a loan fund but the income from a $5,000 bequest is used for a scholarship fund.

Cleveland Visiting Nurse Association—

There are opportunities for post-graduate work. Salary allowance is generally 2 months, depending on the nurse, length of service, etc. Each case considered separately. There is a loan fund or scholarship fund. It is not nearly adequate and is used as fast as it is paid in.

SOURCES OF FUNDS

The sources of scholarships vary. A few organizations have endowments. The Chicago Visiting Nurse Association is peculiarly fortunate in this respect. It has a fund of $40,000, income from which can be used for post-graduate study. Any visiting nurse is eligible after she has been with the association twelve months, if she meets the requirements of the Committee on Scholarships and of the course which she desires to take.

The Evansville Public Health Nursing Association has a $1,200.00 loan fund, known as the Lydia Metz Fund, from which a nurse may borrow up to a maximum of $250.00. This amount is paid back to the Fund at the rate of $10.00 per month. Nurses who are on leave for study are not paid a salary.

In Syracuse, the Junior League raised a scholarship for the Visiting Nursing Association. In Brooklyn, the Rotary Club granted the Association scholarships to train nurses in orthopedics at the Long Island College Hospital. One organization in Pennsylvania makes up its loan fund from the fees received by its staff nurses for lectures given in the training schools.

STATE ASSOCIATIONS

Many of the State Graduate Nurse Associations are raising scholarship and loan funds for advanced study in education, organization, and public health nursing, and for a number of years the State Branches of the N.O.P.H.N. have been building up "educational loan funds." The Minnesota S.O.P.H.N. appointed its Committee in 1924 and Kentucky in 1926. New Jersey, Oregon, Texas, and Washington are adding slowly to their funds. In Pennsylvania, the Education Committee of the S.O.P.H.N. has stimulated interest by sending out a questionnaire to 16 public health nursing organizations in the state. Replies were received from all these organizations, but only 4 had ever given scholarships and one had given a loan. Four replied that no salary was given during the course. The qualifications mentioned were "educational requirements of the post-graduate school, intelligence, efficiency as a public health nurse, interest, satisfactory work in the district, ambition, true spirit of nursing." One organization had its scholarship nurse report on her study each month. Another required the nurse to give a report to the Executive Board after completion of the course. Three organizations reported that these scholarships "had stimulated interest and ambition on the part of the other members on the staff."

OTHER PROFESSIONAL GROUPS

Besides the state organizations, other professional groups have felt the need for scholarship and loan funds. The alumnae associations of the Public Health Nursing Courses at Simmons College, University of Michigan, Columbia University, Western Reserve University and the University of Washington, have loan funds raised by their own graduates to help other students equip themselves for public health nursing. The Alameda County Nurses' Association has recently established at the University of California a

loan fund of $25,000, the interest of which is to be used as a loan, or loans, given to active members of the association who wish to take advanced scientific or cultural subjects. The loans are made without interest during the period that the recipient is resident at the University, but become interest bearing, the rate being nominal or small, upon the departure of the recipient from the University.

Hospital alumnae associations are beginning to look beyond the needs of their own training schools and are stimulating interest in post-graduate work. An example of this is the Alumnae Association of the Sacred Heart Hospital, Manchester, N. H., which has formed a scholarship fund in order that any member of the association desiring to further specialize in public health or nursing education might do so providing she is eligible.

SPECIAL FUNDS

Public health nurses are already familiar with the help offered by the various colleges and universities giving public health nursing courses (see course folder published by the N.O.P.H.N.). This year the list of scholarships had an interesting addition in the announcement of the Julius Rosenwald Fund of scholarships for negro nurses. This last month the Commonwealth Fund has announced a plan of coöperation with health departments to promote rural work. According to this plan, post-graduate fellowships will be given to nurses actually employed in states where the projects are developed.

As there is every reason to hope for a consistent increase in the number of college graduates attracted to nursing as a profession, it would seem probable that many nurses would be qualified for the fellowships offered by the American Association of University Women, Washington, D. C. Also, college graduates with public health nursing experience would seem peculiarly fitted for the Fellowships in Child Development offered by the National Research Council. These awards are made under a grant from the Laura Spelman Rockefeller Memorial, and aim to attract workers who will increase scientific knowledge of the child and bring this knowledge to parents and others concerned with child life.

There is another type of "fellowship" not granted for formal study, but for travel. The Rockefeller Foundation is one organization which is convinced of the value of visual experience, and so makes many travel grants for observation tours. The largest number of these are given foreign students. This group from other countries may be responsible for the increasing interest in this method of granting leaves of absence. Unquestionably, travel, wisely planned, is a fruitful means for exchanging experience and broadening public health vision and knowledge. There may come a day when there will be a public health nursing organization like the Charity Organization Society of New York, which grants sabbatical leaves of three months to be used not only in study, but also in travel and recreation.

CONCLUSION

There are several facts which stand out from the material gathered. One is the proportion of organizations which have been able to budget for this form of staff education. While only 8.7 per cent of the 114 official and non-official agencies had felt the need for or had been able to accumulate scholarships and loan funds, over one-half, or 57.8 per cent, had made more or less generous time and fee allowances for extension courses. In addition 33.3 per cent of the organizations either had a policy or had made individual arrangements for post-graduate study for their supervisors. An even greater number, 36.8 per cent, gave leaves of absence to field nurses. These figures make one realize that the public health nursing profession is not a static thing, but that increased experience only points out increasing needs for knowledge.

Another outstanding fact is the flexibility of the practices in the various organizations, arrangements vary-

ing according to budget, local educational resources, and the qualifications of staff and supervisors in relation to the local program. In connection with this latter factor, a demand for some new public health nursing service has often been the stimulus for the nursing committee to arrange special lectures for staff education or leaves of absence. For instance, an agency which has awakened to its local mental hygiene needs realized that it is legitimate to expend organization funds to finance the education of the staff, in a better understanding of the program.

Another fact which is brought out, more in discussion of the problem than in any statistical figures, is the preferance given loan plans over scholarships. This is partly because a fund can be made to serve more individuals under such a scheme and partly because of the psychological effect on the recipient. With the gradual increase in salaries and the training in thrift fostered by such schemes as the Harmon annuities, it is to be expected that public health nurses will budget to include further study as well as savings, food, and rent. An increasing number of public health nurses can therefore finance their own leaves of absence for post-graduate study or else will expect to refund any loans made at the usual rate of interest.

Finally, it is stimulating to note the evidences of sincere interest in the training of public health nurses on the part of the general public. Individual members of public health nursing boards and committees have made many sacrifices to further the training of the nurses under their jurisdiction. It is also impressive that the nursing profession itself has been active in accumulating funds for further training. They have been led not by any abstract belief in "Higher Education," but by the urge to maintain the best standards of work and the finest possible service to the individuals in their communities.

Rhode Island is to hold an all day institute for lay people interested in public health nursing, on March 27 at Grace Church Parish House, Providence, R. I. Mrs. M. W. Weeden, Chairman of the Board and Committee Members Section of the Rhode Island State Organization for Public Health Nursing, will preside.

The New Phister Hotel has been designated as headquarters for board and committee members at the Biennial Convention at Milwaukee, June 9–14. One hundred and eighty rooms are available, so please write as soon as possible for reservations.

NOMINATIONS FOR OFFICERS AND DIRECTORS OF THE BOARD AND COMMITTEE MEMBERS SECTION OF THE N.O.P.H.N.

Suggestions will be welcomed by the Nominating Committee of which Miss Gertrude Peabody is chairman.

Election will take place at the Biennial Convention in June in Milwaukee. For your convenience the present officers of the Section are here listed:

Chairman—Mrs. Whitman Cross, Washington, D. C.
Vice-Chairman—Mrs. C.-E. A. Winslow, New Haven, Conn.
Directors—Mrs. A. R. Flickwir, Houston, Texas.
Miss Alice Griffith, San Francisco, Calif.
Mrs. Richard Noye, Buffalo, N. Y.
Miss Anna M. L. Huber, York, Pa.
Nurse Directors—Miss Ruth Houlton, Minneapolis, Minn.
Miss Juanita Woods, Richmond, Va.
Mrs. Ivah Uffelman, Nashville, Tenn.

POLICIES AND PROBLEMS OF PUBLIC HEALTH NURSING

A MARIONETTE SHOW

Community chest and county fair exhibitors will find of unusual interest a novel exhibit displayed by the Visiting Nurse Association of Hartford which aroused favorable comment in that city. A marionette show telling the story of the visiting nurse and the service she performs was put on in a window of one of Hartford's largest department stores, situated in the heart of the business district. The voices of the puppeteers were heard outside the window through a public address system of amplifiers.

The nurse in the play calls at the tenement of the Carters to dress the broken arm and injured foot of the husband, who has been hit by a hit-and-run driver. She finds that Mrs. Carter has tuberculosis; the 14-year-old boy Tom is a mental case, being uncontrollable at home; the 9-year-old girl Mary has a sore throat and swollen tonsils; and the baby has rickets and temper tantrums. After attending to the father, the nurse promises to arrange financial aid for the family, medical services for the girl, expert advice for the mother in the care of the baby and Tom and a chance for the mother to go to a sanatorium, having the children cared for while she is away. The play gives graphically a cross section of the service given by the Visiting Nurse Association.

The success of this exhibit necessitated the boarding of the base of the window as a protection against the pressure of the crowd that thronged consistently at each performance. Between performances the stage was on display and attracted constant attention.

During the whole year the Hartford Visiting Nurse keeps exhibits in different windows throughout the city, changing the windows from time to time to different sections of the city; thus keeping the work before the public at all times. During the week of the campaign this association had five window displays in addition to the main window exhibit of the marionettes.

SPIC AND SPAN!

A business office in Columbus, Ohio, has placed a large mirror in a position where every salesman must face it as he leaves the office. Above the mirror is this sign: "Your appearance will have either a favorable or an unfavorable reaction upon every prospect you meet today Look yourself over."

Wouldn't this suggestion apply to public health nurses as well?

A PILLOPHONE!

The latest device for the entertainment of invalids is a Pillophone. It consists of a radio receiving unit embedded in sponge rubber and contained in a pillow covering. The user merely rests his head on the pillow and listens to his favorite programs without fatigue and without disturbing anyone else. It takes the same electric energy as a pair of earphones, and may be switched off at the radio set, or at the pillow. It is "unbreakable and hygienic," and is in use in British hospitals.

THE VEGETABLE HOUSE

The commercial exhibits at the Congress of the International Council of Nurses in Montreal were extremely interesting and widely representative. The Daily Branch of the Agricultural Department of Ottawa sent in a very clever exhibit called "Health House." It consisted of a large doll's house made entirely of health-giving foodstuffs. The foundations were of peas and beans, the walls of wholemeal, and the roof of Graham biscuits; the shutters were formed of slices of whole wheat bread, the curtains of lettuce leaves. The veranda was formed of columns of macaroni rising from steps and stumps made of cheese, and the path was of rice edged with nuts.

REVIEWS AND BOOK NOTES

Edited by DOROTHY DEMING

THE CHALLENGE OF CHRONIC DISEASES

By Ernst P. Boas, M.D., Attending Physician, Montefiore Hospital for Chronic Diseases, and Nicholas Nichelson, M.D., Adjunct Physician, Montefiore Hospital for Chronic Diseases

The Macmillan Co., New York, N. Y. $2.50.

The dilemma of the chronically ill is presented in this compact little book by authors who write from an exceptional background of knowledge and understanding of their subject.

The ever mounting problem of this notably neglected group of patients is discussed from the social and economic as well as the medical angle. Various means are suggested for meeting more rationally and humanely certain manifest needs particularly along the lines of institutional care, as this is "the most important of all the possible communal methods of relief."

One of the valuable features of the book is the clear defining of so-called "chronic" patients in contra-distinction to "incurables," "aged" and "convalescents," also the classification of these patients according to their medical needs as:

Class "A"—Patients requiring medical care for diagnosis and treatment.

Class "B"—Patients requiring chiefly skilled nursing care.

Class "C"—Patients requiring only custodial care.

The closing chapters of the book are devoted to the details of a hospital designed for the adequate care of the three groups of patients. Montefiore Hospital for Chronic Diseases, New York City, with which the two authors have long been associated, supplies much excellent illustrative material and it will hearten the reader to learn of the work, unique in its field, that this hospital is doing.

Anyone reading this book will be stirred to a greater concern regarding the facilities for the care of those suffering with chronic diseases in his or her own community.

HELEN V. STEVENS

THE CHILD'S HEREDITY

By Paul Popenoe

Williams and Wilkins Co., Baltimore, Md., 1929. Price $2.00.

Although of a size formidable to the busy nurse, the style of this book is so readable and the contents so interesting and logical in sequence that pages and time pass quickly. This is the kind of book we like to mark as we go along for excellence of certain phrases or completeness and compactness of expression.

Those fairly familiar with the subject of heredity will recognize much familiar material but in fresh garb. Mr. Popenoe takes his subject out of the experimental laboratory into the field of human experience.

The central section of the book is given over to discussion of heredity of special tendencies. This part is not so readable as the more general discussions at the beginning and end of the book. It is more useful for reference, to follow up some special interest. It is very inclusive, discussing such physical characteristics as the skin and hair and eyes, such special interests as left handedness, through diseases of the body, to intelligence, temperament, mental diseases, and special abilities.

The author states that the book is written for parents. It might be well for the over-solicitous parent not to dip too deeply into the recital of abnormalities. However, perhaps one of the chief values of the book lies in the exploding of popular fears relative to heredity.

Frankly an hereditarian, Mr. Popenoe gives an excellent defense of his position. He draws together what appear to be all of the recent reliable studies of heredity. The book presents an excellent review of all that is known on the subject up to the present time. ROSAMOND PRAEGER

The Parents' Magazine is priding itself on the publication of *The Modern Baby Book and Child Development Record.* It is an ambitious volume appropriately garbed in pink and gives an opportunity to parents to keep an intimate detailed account of a child's life. As the foreword states: "The old-fashioned baby books contained a collection of snapshots, cute sayings, locks of hair and what not—this book will measure a child's growth and development in a truly scientific record from birth to 16 years." The volume may be purchased from W. W. Norton & Company, New York City.

The sixth edition—which always speaks well for a book—of Dr. Robert S. McCombs, *Diseases of Children for Nurses,* has just been issued. (William B. Saunders Company, Philadelphia, Pa.—Price $2.75.) Chapter XX will be found useful for reference for those who wish to polish up their tarnished knowledge of child nursing procedures and therapeutics.

The fourth edition of *The Newer Knowledge of Nutrition* by E. V. McCollum and Nina Simmonds (The Macmillan Company, New York, N. Y., $5.00) has just been published. Among the striking features of the new edition are recent findings in relation to anemias, iodine and the control of goitre, the story of the discovery of ergosterol, and of vitamin G.

The Bureau of Home Economics of the U. S. Department of Agriculture has issued nine charts picturing the effect of proper and improper diet on rats and guinea pigs. The charts will be particularly useful in upper grade and high school health education.

A new pamphlet—*Vitamins in Food Materials* by Sybil L. Smith has been prepared by the United States Department of Agriculture (Circular 84). The tables showing vitamin A, B, and C content of foods are the most comprehensive so far published. To be secured from the Superintendent of Documents, Government Printing, Office, Washington, D. C.

The Committee on the Cost of Medical Care has issued a report on the first two years of its work. This may be secured from the committee, 910 Seventeenth Street, N. W., Washington, D. C., as may also abstract of Publication No. 2: *The Extent of Illness and of Physical and Mental Defects* in the United States—a compilation of existing material.

Dr. Richard M. Smith, Assistant Professor of Child Hygiene at Harvard Medical School and one of the wellknown pediatricians of the country, has written *Between Two Years and Six* for the Life Conservation Service of the John Hancock Mutual Life Insurance Company. As its name implies, this book is concerned with the hygiene of the preschool child and covers not only the physical care of the child in health and illness, but includes a discussion of mental health as well.

An unusual feature is the provision of a place for recording the child's development from year to year, so that a record may be preserved for the guidance of the mother and the physician who may see the child from time to time. This booklet will be supplied free to nursing associations if requested from the Company, Boston, Massachusetts.

Borden's Farm Products Company, Inc., has a supply of attractive colored posters for use in health education work. The value of milk is stressed. The Bureau of Nutrition will supply these free and furnish information on production, marketing and grading of milk, also diets and recipes using milk.

Standing Orders, Bag Technique and Nursing Equipment for American Red Cross Public Health Nurses (A.R.C. 721) have just been issued by the American Red Cross. All of the routines and suggestions are valuable—indeed indispensable to any public health nurse. We note particularly the description of a county nurse's bag—suitable only for the nurse who drives a car:

> This bag is designed for the use of county nurses carrying a generalized service including school nursing and some emergency bedside nursing. It weighs 4¼ lbs. empty.
>
> It is made of brown, high grade heavy strap leather, on a stiff base, with straps, lock and reënforced handle. Its outside dimensions are 15¾" by 10½" by 7".
>
> It has 4 leather partitions making 5 pockets. Four of these, two full width and two half width, are for records, literature, charts, etc. The fifth has a washable removable lining with pockets for bottles and other nursing supplies.
>
> These bags are sold by the American Red Cross for $11.00.

The leaflet also contains a list of Reserve and Loan Supplies, as well as lists of special outfits.

A brief guide to nursing procedure and technique for follow-up nurses has been issued by the U. S. Veterans' Bureau, Washington, D. C.

For club groups interested in child study the American Library Association has just issued a study outline on the preschool child which was prepared to accompany a reading course *The Young Child* issued some time ago. The reading course, one of the Reading with a Purpose series, is by Bird T. Baldwin; the study program by Grace E. Crum, Associate Manager of the Bureau of Parental Education of the National Congress of Parents and Teachers.

The study program was designed as a special guide to clubs wishing to concentrate upon the study of the young child. It, together with the reading course and the six books suggested for reading, will furnish material for a well organized season's study. Questions with chapter and page references to the half dozen books develop these topics for the reader.

The study program, the reading course and the necessary books are available at most libraries. Club and study groups may also get the outline and the reading course from the American Library Association at nominal prices for quantities.

The first children's library yearbook to make its appearance is prepared by the American Library Association's Committee on Library Work with Children and is published by the Association (520 N. Michigan Avenue, Chicago, Ill. Price $2.00). A survey of thirty years of children's books, a discussion of modern tendencies in books for children, of story-telling as a method of directing the reading of children, of county service to the rural child, of adult and juvenile departments, and a list of important children's books of 1928 are some of the highlights of this unique and worthwhile undertaking. It is expected that various other aspects of the subject will be treated in yearbooks which are to follow.

Your Child's Teeth, by Percy R. Howe, D.Sc., D.D.S., Director of the Forsythe Dental Infirmary, Boston, Mass., is a recent publication of the U. S. Children's Bureau—Folder No. 12, Washington, D. C.

It contains simple and practical suggestions for the mother about the care needed to insure good teeth for her children. Directions are given with regard to diet in babyhood and early childhood, dental care, and helping the teeth to resist decay.

Ward Administration, by Gladys Sellew—W. B. Saunders Co., Philadelphia, 295 pages, illustrated, has several chapters of great interest to administrators and supervisors in public health nursing associations. Correlation of procedures is easily made—see especially chapters on Supervision, Staff, Education and Promotion of Health.

NEWS NOTES

Many subjects are listed on the program of the First International Congress on Mental Hygiene. Practically all aspects of mental hygiene will be covered at the Congress. Details of the program have been worked out by a committee of which Dr. Frankwood E. Williams, medical director of the National Committee for Mental Hygiene, is chairman. Topics are now ready for publication, and are contained in a *Preliminary Announcement*, obtainable from headquarters office. The Congress will be held in Washington, D. C., May 5–10, 1930. President Hoover has accepted the honorary presidency of this Congress, and delegates are expected from more than thirty countries.

The following are some of the topics of special interest to public health nurses:

Magnitude of the mental hygiene problem as a health problem.

Organization of community facilities for prevention, care and treatment.

Organization of the mental hospital and its rôle in community life.

Care and treatment of mental patients outside of institutions.

Types of personnel required in mental hygiene work (physician, psychologist, nurse, social worker, and occupational therapist).

Mental hygiene in industry, personnel work and vocational guidance.

Special problems of adolescence.

Problems presented by children of special type: (1) the child with superior intelligence; (2) the neurotic child; (3) the child with sensory and motor defects.

Methods and possibilities of the child guidance clinic.

Significance of parent-child and teacher-child relationships in character and personality development.

Problems of the preschool period.

The American Psychiatric Association and the American Association for the Study of the Feebleminded will hold their annual meetings in Washington at the same time as the First International Congress.

The American Conference on Hospital Service will meet Tuesday, February 18. A program may be obtained from the Conference headquarters, 18 East Division St., Chicago.

The College of the City of Detroit, Michigan, is planning to build up a department of public health nursing. Katherine Faville, R.N., will be head of this department, as associate professor.

Miss Maude Hall, formerly attached to the Public Health Clinic, Dalhousie University, Halifax, has been appointed Assistant Superintendent of the Victorian Order of Nurses for Canada.

A Registered Nurses' Aviation Association has opened offices in Rooms 308–313, Palmer House, Chicago, with Mrs. Laura Belle Ermann Richter as President. Its purposes are to promote and prepare for adequate nursing facilities at airports and to make nurses familiar through flying experience with flying emergencies.

The following additions are made to the Official Directory published in January:

North Dakota

Section on Public Health Nursing of State Graduate Nurses' Association—Chairman, Mabel Draxton, R.N., Wahpeton; Vice-Chairman, Margaret Skaarup, R.N., La Moure; Sec. and Treas., Gene Johnson, Fargo.

Wyoming

Section on Public Health Nursing of State Graduate Nurses' Association—Chairman, Edith I. Stallard, Box 637, Cheyenne.

Philippine Islands

Philippine Islands Anti-Tuberculosis Society—Field Nurses: Emilia Lantin, Salvacion Ibarra, Manuela Novero, Dorotea Libao, Felisa Pahati, Mrs. Ismaele A. Caces.

Pennsylvania (corrected statement)

State Organization for Public Health Nursing—Pres., Leslie Wentzel, Scranton. Vice-Pres., Mrs. Anna Barlow, Reading. Sec., Winifred L. Moore, York. Treas., Elizabeth Scarborough, Philadelphia. Chairman Lay Membership Committee, Anna M. L. Huber, York. Chairman Membership Committee, Mildred Martin, 25 East Athens St., Ardmore.

The health institute recently held in New York City under the joint auspices of the New York State Federation of Women's Clubs and the State Congress of Parents and Teachers had for its immediate purpose the instructing of lay workers in how to recognize the health needs of their communities and in what can be done to improve these conditions. Delegates at the institute were the health chairmen of the two groups mentioned. They represent together 150,000 women.

APPOINTMENTS

The Joint Vocational Service announces the following appointments:

Ruth Taylor as District Head Nurse, Cattaraugus County Health Department, New York, with headquarters at Ellicottville, New York. Constance Wood is assisting Miss Taylor as a staff nurse.

B. B. Randle, formerly supervisor of school nursing in the Cattaraugus County Health Department as Supervisor of School Nursing for the Board of Education and Board of Health, Grand Rapids, Michigan.

Tessa deAlberti as public health nurse for the maternity clinics of St. Joseph's Hospital, Yonkers, New York.

Muriel K. Holland of Cobalt, Ontario, Canada, as public health nurse, Phillipstown Public Health Nursing Association, Garrison, New York.

Olive Meyer as Superintendent of the Public Health Nursing Association, Woonsocket, R. I.

Alexandra Matheson will reorganize and be director of the Visiting Nurse Association, Yonkers, N. Y., beginning in January.

Mrs. Laurie Jean Reid has resigned as Director of the Bureau of Child Hygiene and Public Health Nursing, Florida State Board of Health.